

EPSDT Manuals

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Table of Contents

EPSDT Supplement B	3
<i>Provider Risk Category Table</i>	56
EPSDT Personal Care Services	59
EPSDT Nursing	97
EPSDT Appendix A	119
EPSDT Inpatient Services	137
EPSDT Audiology and Hearing	161

EPSDT Manuals

EPSDT Supplement B

GENERAL INFORMATION ON EPSDT SERVICES

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT is a Medicaid benefit and therefore there are no special enrollment procedures for members to access EPSDT services.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements. EPSDT provides examination and treatment services at no cost to the enrollee.

DMAS, its contracted MCOs and their providers have the responsibility to provide EPSDT diagnostic and treatment services according to the DMAS periodicity schedule to all Medicaid/FAMIS fee-for-service/FAMIS Plus enrollees under age 21. The full scope of EPSDT treatment is available to all children in Medicaid/FAMIS Plus regardless of their chosen MCO. Individuals aged 19 or 20 who are covered under Medicaid expansion are eligible for EPSDT.

FAMIS

Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO) in most parts of the state. Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The EPSDT diagnostic and treatment benefit is available to FAMIS Fee-for-Service

enrollees.

EPSDT Goals

The goals of EPSDT are to identify health concerns, assure that treatment is provided before problems become complex, and to medically justify that services are provided to treat or correct identified problems.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

- EPSDT periodic screenings or well child check-ups - checkup that should occur at regular intervals.
- EPSDT/Inter-periodic Screenings, sick visits - unscheduled check-up or problem focused assessment that can happen at any time because of illness or a change in condition.

EPSDT also covers other services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan.

All treatment services require service authorization (before the service is rendered by the provider).

The required EPSDT services under Section 1905(r) of the Social Security Act are described below.

Screening Services

Required EPSDT screening components include:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Vision screening by a standardized testing method according to the DMAS periodicity schedule;
- Hearing screening by a standardized testing method according to the DMAS

periodicity schedule;

- Developmental screening with a standard screening tool according to the American Academy of Pediatrics guidelines;
- Age appropriate immunizations as needed according to the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Laboratory tests (including lead blood testing at 12 and 24 months or for a new patient with unknown history up to 72 months or as appropriate for age and risk factors);
- Health Education/Anticipatory Guidance/problem-focused guidance and counseling.

The chart below indicates when a child should receive an EPSDT screening:

INFANCY	EARLY CHILDHOOD	LATE CHILDHOOD	ADOLESCENCE
3-5 days	12 months	5 years	11 years
1 month	15 months	6 years	12 years
2 months	18 months	7 years	13 years
4 months	2 years	8 years	14 years
6 months	30 months	9 years	15 years
9 months	3 years	10 years	16 years
	4 years		17 years
			18 years
			19 years
			20 years

The “EPSDT Screening Services” section located within this chapter provides detailed EPSDT screening information.

Other Necessary Health Care, Diagnostic Services and Treatment Services – Specialized Services

As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, the state must provide other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects

and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The non-state plan services are called Specialized Services.

The state may determine the medical necessity of the service and subject the service to service authorization for purposes of utilization review.

In addition to the traditional review for medical necessity, Medicaid children who are denied services that do not meet the general coverage criteria must receive a secondary review to ensure that the EPSDT provision has been considered. The DMAS, service authorization contractor, and MCO secondary review process for medical necessity must consider the EPSDT correct or ameliorate criteria. The Department must approve the MCO's second review process for EPSDT prior to implementation or when requested. Denial for services to children cannot be given until this secondary review has been completed.

No service provided to a child under EPSDT can be denied as "non-covered", "out-of-network" and/or "experimental" unless the approved secondary review applying EPSDT criteria has been completed and determined that it is not medically necessary.

Outreach and Informing

Federal EPSDT regulations provide that all eligible Medicaid/FAMIS fee for service/FAMIS Plus members under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them. Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation.

Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS), participating MCOs, primary care physicians (PCPs) and EPSDT screening providers.

DSS provides the following information about EPSDT services to Medicaid applicants during the initial eligibility interview including the following:

- Informs families of the benefits of regular preventive health care for their children;
- Informs families on the range of services available, and how to obtain these services;

- Informs families that the services are provided at no cost to them; and;
- Informs families on the available necessary transportation and appointment scheduling assistance.

The Managed Care Help Line staff informs members of EPSDT services and encourages them to contact their primary care physician or a Medicaid enrolled EPSDT provider as soon as possible to schedule screening appointments for their children. DMAS also sends periodic mailings based on the member's date of birth to all Medicaid/FAMIS fee-for-service/FAMIS Plus enrolled families to encourage their participation in EPSDT.

MCO informing and outreach responsibilities must include, at a minimum, promotion of EPSDT for new enrollees, including urging them to contact their primary care provider to schedule an initial screening, a clear description of EPSDT services in the member handbook and ongoing member education services encouraging participation in these services.

DEFINITIONS

Activities of Daily Living (ADLs): Activities usually performed in the course of a normal day in an individual's life; and may include eating, dressing, bathing and personal hygiene, mobility including transfer and positioning, bowel and bladder assistance.

Administrative Dismissal:

1. A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
2. The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action: The termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination: Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service,

including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) the failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) for a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

Appeals:

1. A *member appeal* is:

- a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
- b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2. For services that have already been rendered, a *provider appeal* is:

- a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal

regulations at 12 VAC 30-20-500 *et seq.*; or

- b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

DMAS: The Virginia Department of Medical Assistance Services (DMAS) is the state Medicaid agency that is responsible for administering the EPSDT benefit.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment): a Federal law (42 CFR § 441.50 *et seq.*) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, EPSDT provides examination and treatment services at no cost to the enrollee.

EPSDT Screener: DMAS enrolled or contracted Medicaid MCO enrolled Physician, Physician's Assistant, or Nurse Practitioner.

EPSDT Screening: EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;

- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and health education, including anticipatory guidance.

FAMIS: Virginia's program that helps families provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid. In Virginia, FAMIS enrollees are not eligible for some types of EPSDT specialized services when enrolled in a managed care organization.

FAMIS Plus: FAMIS Plus is the name given to the Virginia Medicaid program.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program that uses the DMAS provider network to deliver healthcare services. "FAMIS fee for service" enrollees are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Internal Appeal: A request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Service Authorization (SA): The process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services. Providers and individuals are notified of each SA decision with a system-generated notice. SA for specialized inpatient services for FFS enrollees is obtained at DMAS. SA for Managed Care enrollees must be obtained through the MCO.

State Fair Hearing: The Department's evidentiary hearing process for member appeals.

Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

State Plan for Medical Assistance: The set of benefits approved by the Commonwealth of Virginia and the Centers for Medicaid and Medicare Services.

Third Party Liability (TPL): Insurance other than Medicaid that is owned by the individual or purchased on the individual's behalf. This insurance may be liable for coverage of the requested Medicaid service. TPL must be billed for services prior to billing Medicaid.

EPSDT SCREENING SERVICES

Qualified EPSDT Screening Providers

Qualified providers of EPSDT screening services include:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine under supervision as required by their license;
- A nurse practitioner licensed by the Boards of Medicine and Nursing and acting within the scope of practice;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs);
- Local health departments;
- School based health clinics; and
- Other DMAS approved clinics

EPSDT providers must be Medicaid enrolled providers and must meet all applicable Medicaid provider and specific EPSDT screening requirements. There are no additional enrollment requirements for qualified providers to participate in EPSDT.

The Primary Care Physician's Role in Screening

PCPs for children in MCOs must directly provide EPSDT services for all children assigned to them. Those children who are not enrolled in managed care may obtain these services from any Medicaid enrolled physician or clinic qualified to provide EPSDT services and also offers these services. These qualified Medicaid enrolled fee-for-service EPSDT providers must follow the same requirements indicated in this manual. The Managed Care Help Line maintains a list of these providers. EPSDT is a Medicaid benefit and therefore there are no special enrollment procedures for members to access EPSDT services.

The PCP or EPSDT screening provider (both MCO and FFS), must perform the following activities related to screening services:

- Advise families of the importance of regular preventive health care for their children and explain EPSDT services.
- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS periodicity schedule and screening requirements.
- Assure that the initial screening is scheduled within thirty (30) days of notification of managed care assignment and immediately upon notification of newly assigned newborns unless the services are declined.
- Notify families when the next screening is due including those families who have previously declined screening services and encourage them to keep all screening appointments.
- Schedule the next screening appointment and maintain periodicity and tracking system on screenings.
- Follow up on missed or incomplete screenings including contacting families and rescheduling the screenings promptly.
- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other health care services.
- Maintain a comprehensive and integrated medical record of all health care the child receives including complete documentation of all EPSDT screening components and immunizations given.

MCOs may assume responsibility for some of the informing, tracking and notifying functions of PCPs. One of the primary goals of DMAS' managed care programs is to promote a

“medical home” for children so that members under the age of 21 receive both sick and well care from their PCP rather than seek episodic care from an emergency room. A PCP who chooses not to directly provide screening services must enter into a formal written agreement with a local health department, FQHC, or other qualified EPSDT provider to provide screening services to children in his panel. The referral duration will be at the discretion of the provider, and must be fully documented in the patient's medical record. “Exhibits” at the end of this chapter contains an optional referral form for this purpose. Regardless of the screening arrangements, the PCP must continue to be responsible for the informing, tracking, follow-up and documentation requirements of EPSDT.

The EPSDT Screening Periodicity Schedule

EPSDT screenings are Medicaid’s well child visits and should occur according to the “American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care”. The DMAS periodicity schedule is included as Appendix 1 under “Exhibits” at the end of this chapter. Providers must obtain a medical history that is inclusive of mental health risk factors and documents the family’s history of mental health conditions.

EPSDT screenings, inter-periodic screenings and the required components of the screenings do not require service authorization requirements. However, screenings not performed by the child’s PCP may require a referral from the PCP. Children not enrolled in managed care are not subject to this referral requirement.

EPSDT Screening Components

This Section describes the required components of EPSDT screenings for members enrolled in Fee for Service and Managed Care Organizations. The EPSDT comprehensive health screening/well child visit content should be in line with the most current recommendations of the **“American Academy of Pediatrics (AAP), Guidelines for Health Supervision”**. Another resource for preventive health guidelines is the AAP compatible **“Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents”**. All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.

The following is a description of each of the required age appropriate screening components:

Comprehensive Health and Developmental/Behavioral History

At the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child’s parents or

a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

- Family medical history (health of parents and current family members, identification of family members with chronic, communicable or hereditary diseases);
- Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies and current health problems and medications);
- Nutritional history;
- Immunization history;
- Environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home);
- Family background of emotional problems, problems with drinking or drugs or history of violence or abuse; and
- Patient History of behavioral and/or emotional problems (educational environment and performance, family and social relationships, hobbies, sports).

In addition, for all adolescent children, the initial history must include:

- History of sexual activity, if appropriate
- Menstrual history for females
- Obstetrical history, if appropriate

The history must be updated at each subsequent screening visit to allow serial evaluation.

Developmental Surveillance, Assessment, and Screening

Developmental surveillance should be conducted at each well-child visit. Developmental surveillance is the process of recognizing children who may be at risk of developmental delays. Surveillance is longitudinal, continuous, and cumulative and is comprised of the following components: parental concerns; developmental history; observation of the child; identification of risk and protective factors; and accurately documenting the process and findings. The following are examples of conducting surveillance:

- Parental concerns: Simple questions to parents such as “do you have any concerns about your child’s development? Behavior? Learning? Asking about *behavior* can help identify issues, as parents may not be able to differentiate between development and behavior.
- Developmental history: Ask parents about changes since the last visit, and questions about age-specific developmental milestones such as walking, pointing, etc.

- **Observation:** The health care provider can often see evidence of age-specific developmental milestones, and may be able to confirm parental concerns. It is also important to monitor the parent's response to the infant, and vice versa.
- **Risk and protective factors:** Infants born prematurely, at low or very low birth weight, or with prenatal exposure to alcohol, drugs, or other toxins are at risk for developmental delay. Protective factors to support infants at risk, such as participation in home visitation program, or strong connections within a loving and supportive family, should also be considered in determining the overall degree of risk.

Surveillance services are always a subjective observation by the practitioner. Reimbursement for well child visits includes surveillance activities because developmental, hearing and vision surveillance occurs during the course of each EPSDT visit. When a child has an issue that warrants further investigation by the practitioner, then the child may receive a screening to document the need for further assessment or evaluation.

DEVELOPMENTAL SCREENING TOOLS

If at any time developmental surveillance demonstrates a risk for developmental delay, a standardized screening tool should be administered to further assess the child. As recommended by the AAP, developmental screening using a standardized screening tool should occur at 9, 18, 24 and 30 months of age or at any time when surveillance indicates a risk for developmental delay. An autism specific screening is recommended at the 18 and 24 month visit. Children should be screened for developmental concerns at least 5 times while they are younger than three years of age.

Developmental assessment and screening differs from surveillance because the activity of assessment and screening includes the use of a standardized developmental screening tool. The tools used may vary according to the type of screening or assessment that is provided. All of the examples listed below can be performed by a parent or other office staff and interpreted by the physician during the "face to face" portion of the child's visit. These tools are designed to be used easily as part of the typical office work flow and the tools are very sensitive and specific with proven statistical validity.

Recommended Developmental Screening Tools

Parents' Evaluation of Developmental Status (PEDS),	Parent-report instrument used to identify general developmental delay in the general primary care population
Ages and Stages Questionnaire (ASQ),	Parent-report instrument used to identify general developmental delay in the general primary care population and/or broad high-risk population

Bayley Infant Neurodevelopmental Screen (BINS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	Parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	Practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	Parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Recommended Tools for Focused Screening for Suspected Health Conditions:

Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	A parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	Practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	Parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Hearing and Vision Screening and Surveillance

Subjective

The subjective screening for hearing and vision is part of the comprehensive history and physical examination. Children's hearing is assessed according to the AAP policy for "Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening". Children's vision assessment should be provided according to the AAP policy for "Eye Examination in Infants, Children, and Young Adults by Pediatricians". Hearing and

Vision screenings follow the most current AAP periodicity schedule as stated in the AAP “Recommendations for Preventive Pediatric Health Care”.

The Virginia Early Hearing Detection and Intervention (EHDI) program, the AAP, and the American Speech-Language-Hearing Association provide information on objective hearing screening methods for infants and toddlers.

The EHDI program has a resource, Protocols for Medical Management, that defines best practices for caring for infants and young children who are in need of follow-up from universal newborn hearing screening programs and for children who are found to have hearing loss. The Early Hearing Detection and Intervention protocols can be accessed the Virginia EHDI Program Web site, <http://www.vahealth.org/hearing/>. Early and consistent intervention specific to hearing loss is essential to achieving normal language development.

Information on vision assessment and surveillance may be found in The American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the American Academy of Pediatrics Section on Ophthalmology.

Screening and Testing Using Standardized Methods

The provision of hearing or vision testing using a standardized instrument during the well child visit is billable on that service day as a distinct service. Hearing and vision testing using a standardized instrument is eligible for reimbursement when performed according to the DMAS periodicity schedule or when required to monitor the progression of hearing or vision loss related to the presence of identified risk factors.

Virginia Law Regarding Hearing Screening at Birth

Virginia law requires that all infants receive a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Comprehensive Unclothed Physical Examination

A complete unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques using the criteria for specific age groups described in the latest edition of the AAP *Guidelines for Health Care Supervision*. The examination must include all

body parts (or areas) and systems listed below:

- Cranium and face
- Hair and scalp
- Ears
- Eyes
- Nose
- Throat
- Mouth and teeth
- Neck
- Skin and lymph nodes
- Chest and back (using a stethoscope) to check for heart and lung disorders
- Abdomen
- Genitalia
- Musculoskeletal system
- Extremities
- Nervous system

The examination must include screening for congenital abnormalities and for responses to voices and other external auditory stimuli. Evaluation of the Tanner stage and scoliosis screening must be included as part of the complete physical examination at each screening visit beginning at age ten.

In addition, the height (or length) and weight of the child must be measured. When examining a child two (2) years of age and younger, the provider must measure the child's occipital-frontal circumference. All measurements must be plotted on age-appropriate, standardized growth grids and evaluated.

Evaluation of growth and laboratory measures is useful for assessing nutritional status. Assessing eating habits in relationship to developmental stage is also important. If dietary or nutritional problems are identified, a referral to the appropriate professional should be made.

For children three and above, the physical examination must include blood pressure measurement.

As part of the physical examination, excessive injuries or bruising that may indicate inadequate supervision or possible abuse must be noted in the child's medical record. If there is suspicion or evidence that the child has been abused or neglected, State law requires medical professionals to promptly report it to the Department of Social Services' Hotline 1-800-552-7096 (*Code of Virginia* Section-63-248.3).

Immunizations and Laboratory Tests

Age appropriate immunizations should be provided according to the Advisory Committee on Immunization Practices (ACIP) guidelines. All "catch up" schedules for missed vaccines should follow ACIP guidelines.

The child's immunization status must be reviewed from the child's medical record and interview with the parent at each screening visit. If the immunization history is based on the verbal report of the parents or other responsible adult, the information must be confirmed and properly documented, indicating the source.

Age-appropriate immunizations that are due must be administered during the screening visit. Immunizations given to a child during a screening visit may be billed separately. PCPs and other medical screening providers are required to participate in the Virginia Vaccines for Children (VFC) Program and provide necessary immunizations and information about the benefits and risks of immunizations as part of EPSDT screenings. The PCP and screening provider must ensure that every child is immunized according to the current Childhood Immunization Schedule approved by ACIP and AAP. A parent's refusal to allow immunizations must be documented by a statement in the child's medical record that is signed and dated by the parent. If a condition is identified during the screening that warrants deferral of necessary immunizations to a later date, the progress notes in the medical record must so indicate. The provider must follow up to reschedule the child to catch up on immunizations at the earliest possible opportunity.

Vaccines for Children Program

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, childhood immunizations and annual pneumococcal vaccinations are covered according to the most current Advisory Committee for Immunization Practices (ACIP) schedule.

To be eligible for free vaccine from the VFC Program, children must be under the age of 19.

VFC eligible individuals must also meet one of the following criteria:

- Medicaid/FAMIS PLUS, enrolled, including Medicaid MCOs,
- Uninsured (no health insurance),
- Native American or Native Alaskans (no proof required) and
- Underinsured (those whose insurance does not cover immunizations).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC.

Upon enrollment, the Department of Medical Assistance Services will not reimburse the provider for the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (under the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan that the Health Care Financing Administration (CMS) requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check "YES" in Block 11-D (Is there another health benefit plan?) on the CMS-1500 (08-05) claim form. See the Physician/Practitioner Manual for further instructions.

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and

Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid will not reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

Billing for Childhood Immunizations

The Federal Vaccines for Children (VFC) Program provides routine childhood immunizations free of charge to Medicaid-eligible children under the age of 19. These vaccines are provided to VFC enrolled providers by the Virginia Department of Health (VDH). DMAS requires that PCPs serving children and EPSDT screening providers participate in the VFC program. Providers may enroll in the VFC Program by contacting VDH at 1-800-568-1929. DMAS and the DMAS contracted MCOs will not reimburse providers for the acquisition cost of vaccines that are covered under the VFC Program. DMAS reimburses providers for the administration fee for routine childhood vaccines that are available under VFC (under the age of 19). DMAS will reimburse the provider an \$11.00 administration fee per injection.

MCOs are responsible for provider payments of immunizations furnished to children enrolled in MCOs. Therefore, providers cannot be reimbursed by DMAS for immunizations provided to MCO enrolled children.

Reimbursement for Children Ages 19 and 20

Since EPSDT Federal regulations require states to provide coverage for vaccines for children under the age of 21, and VFC provides coverage only under the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. In these instances, the provider must use the appropriate CPT procedure code. DMAS will reimburse the acquisition cost for these vaccines. The charges in locator 24F of the HCFA 1500 (12-90) claim form must reflect the actual acquisition cost per dose. Providers should refer to Chapter V of the DMAS Physician Manual for further billing

guidance.

VFC Coverage of Other Vaccines

The VFC program covers all vaccines in the ACIP immunization schedule, including indications for when a single-antigen vaccine that is normally part of a combination vaccine may be medically appropriate. Claims for single-antigen vaccines that are normally a part of a combination vaccine will automatically pend for review by DMAS staff.

Age appropriate immunizations are a federally required screening component. The provider must not submit a claim for a complete screening unless all required components that are due are administered and documented including appropriate immunizations according to age and history (unless medically contraindicated or the parents refuse at the time). Failure to comply with or properly document this screening requirement must constitute an incomplete screening and may result in denial of payments.

EPSDT REQUIREMENTS FOR LEAD TESTING

As part of the definition of EPSDT services, the Medical Statute requires coverage for children to include both screening and blood lead tests as appropriate, based on age and risk factors. The Centers for Medicare and Medicaid Services (CMS) requires all Medicaid enrolled children receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. The medical record will be deemed insufficient if the child has not been previously screened. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted

<https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf>.

Confirmation of Blood Lead Levels

Blood Lead level testing shall be performed on venipuncture or capillary blood; however, additional testing may be required, as described below. Filter paper methods are also acceptable and can be performed at the provider's office. The use of handheld testing machines must be approved through the Lead-Safe Virginia Program to assure proper quality assurance and reporting of data.

Tests of venous blood performed by a laboratory certified by the federal Centers for Medicare & Medicaid Services in accordance with 42 USC § 263a, the Clinical Laboratory Improvement Amendment of 1988 (CLIA-certified), are considered confirmatory. Tests of venous blood performed by any other laboratory and tests of capillary blood shall be confirmed by a repeat blood test, preferably venous, performed by a CLIA-certified laboratory. Such confirmatory testing shall be performed in accordance with the following schedule (requirements of 12VAC5-90-215):

If result of screening test (µg/dL) is:	Perform diagnostic test on venous blood within:
5-9	1- 3 months
10-44	1 week - 1 month
45-59	48 hours
60-69	24 hours
70 or higher	Immediately as an emergency lab test

For consultation and assistance on the treatment of children with elevated venous blood levels 70 or higher contact Emergency Lead Healthcare through their free medical hotline at 1-866-767-5323 (1-866-SOS-LEAD).

Lead Testing Procedure Codes

If blood lead screening tests are conducted in the providers' offices, the code 83655 for Lead blood testing is used with one of the following: 36416 or 36415, depending on whether

the sample is from a capillary or venous site, as shown below.

Service Description	Procedure Code
Lead Lab Test (paid to Lab or EPSDT screener)	CPT 83655
Capillary Sample (finger, heel, ear stick)	CPT 36416
Venous Sample (recommended)	CPT 36415

When blood lead testing is provided to a client enrolled in a Virginia Medicaid Managed Care Organization (MCO), please follow the MCOs specific billing instructions.

Remember to always verify Medicaid eligibility before services are rendered.

Virginia Regulations for Disease Reporting and Control

The [Virginia Regulations for Disease Reporting and Control](#) require physicians and the directors of laboratories to report any “detectable” blood lead levels in children ages 0-15 years to the Local Health Department within 3 days.

In October 2016, these regulations were updated and “Lead, elevated blood levels” was renamed “Lead, reportable levels”. “Lead, reportable levels” now means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age (12VAC5-90-10). This requirement applies to test results confirmed by a CLIA-certified laboratory. Results of office-based screening tests do not need to be reported.

Many laboratories submit disease reports by means of secure electronic transmission. Reports may also be submitted by using the Epi-1 form that can be found on the Virginia Department of Health (VDH) web site at: <http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf>

For more information, please visit the VDH web site:

<http://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastate-board-of-health/>

Medicaid Funded Environmental Investigations

Environmental investigations are a service offered by Medicaid through Lead-Safe Virginia and local health departments. Environmental investigations are reimbursed to local health departments enrolled with DMAS or contracted with a Virginia Medicaid MCO. Medicaid funds are not available for the testing of environmental substances such as water, paint, or soil. Environmental investigations are conducted when certain criteria are met and may be carried out by private entities or environmental health specialists in local health departments who are licensed risk assessors. For information about what triggers an environmental lead investigation and what it includes, go to <http://www.vdh.virginia.gov/leadsafe>.

For additional questions about environmental lead testing, contact Lead-Safe Virginia toll-free at 1-877-668-7987. You may also email Lead-Safe Virginia at leadsafe@vdh.virginia.gov.

Resources for more information about blood lead testing and lead exposure

Lead-Safe Virginia:

<https://www.cdc.gov/nceh/lead/programs/va.htm>

The National Lead Information Center (NLIC):

Environmental Protection Agency (EPA):

<https://www.epa.gov/lead>

CDC Childhood Lead Poisoning Prevention Program

<https://www.cdc.gov/nceh/lead/>

Coalition to End Childhood Lead Poisoning:

<http://www.greenandhealthyhomes.org/StrategicPlanforEndingLeadPoisoning>

Additional Laboratory Procedures

In addition to the lead toxicity screening, the following procedures on laboratory tests are required:

Neonatal Screening

The screening provider must review the results of the newborn metabolic screening for phenylketonuria, hypothyroidism, galactosemia and other disorders performed prior to hospital discharge.

Sickle Cell Screening

The screening provider must review the results of the sickle cell screening performed prior to hospital discharge on the appropriate population. A sickle cell preparation must be done at the six (6) month old visit if indicated in accordance with AAP guidelines.

Anemia Screening

Iron deficiency anemia screening involving taking hematocrit or hemoglobin values through a finger prick or venous blood sample must be performed at screening visits in accordance with AAP guidelines.

Anemia screening, is a Medicaid reimbursable service, and should be administered more frequently if medically indicated. The results can be shared with the patient's written consent if the certification is needed for the Supplemental Nutrition Program for Women, Infants and Children (WIC).

EPSDT Optional Screening Procedures

The following is a description of **optional** screening procedures to be performed on children and adolescents at risk:

Tuberculin Test (Optional)

Tuberculin testing using the Purified Protein Derivative (PPD) skin test should be performed in accordance with AAP guidelines. The PPD test has replaced the Tyne method.

Cholesterol Screening (Optional)

Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with AAP guidelines.

Sexually Transmitted Disease (STD) Screening (Optional)

All sexually active adolescents should be screened for sexually transmitted diseases such as chlamydia, gonococci, and syphilis at each screening visit beginning at age 11 through age 20. HIV testing should be performed if requested or if the adolescent is at high risk.

Cancer Screening (Optional)

A Papanicolaou (Pap) smear should be performed on all sexually active females at each screening visit.

Pelvic Examination (Optional)

All sexually active females should have a pelvic examination. A pelvic examination and a Pap smear must be offered as part of preventive health maintenance between the ages of 18 and 21.

Anticipatory Guidance

Health Education, also called "Anticipatory Guidance", and problem focused guidance

and counseling are provided at each well child visit according to developmental needs and with respect to patient cultural backgrounds and literacy levels.

The **Bright Futures** program has family friendly materials that provide useful anticipatory guidance information and age appropriate safety and parenting tips. For more information on Bright Futures, go to the web based training module at <http://www.vdh.virginia.gov/brightfutures> DMAS endorses **Bright Futures** and **Bright Futures Virginia**.

Referral to Dental Screening

Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

DOCUMENTATION

The screening provider must retain copies of all screening claims and other Medicaid claims for at least five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. The PCP must maintain complete medical records on all children screened in his or her panel for at least five years from the date of service or as provided by applicable state law, whichever period is longer. Appropriate procedures and systems to ensure confidentiality must be in place. Medical records must contain the following information specific to EPSDT screening services:

- Reason for visit, e.g., screening, follow-up, sick visit. (Note the complaint and relevant

history).

- The date screening services were performed, the specific tests or procedures performed, the results of these tests and procedures, and the specific staff member who provided the service. Each required component of screening including vision and hearing screening and immunizations must be documented separately. The DMAS-353, available in the provider portal, may be used for this purpose.
- Documentation of medical contraindication or a written statement from a parent or a guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations.
- Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening.
- Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as a medical screening.
- Documentation of declination of screening services by parents.
- Documentation of missed appointments and of at least two good faith efforts to reschedule according to the periodicity schedule.
- Referrals made for diagnosis, treatment, or other medically necessary health services for conditions found in screenings and documentation of follow-up done to assure services or treatment were provided within 60 days of the screening.
- Date next screening is due.
- Documentation of direct referral for age-appropriate dental services.

SPECIAL BILLING INSTRUCTIONS

Virginia Medicaid requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS/CPT) codes and definitions published in the current edition of the *Physician's Current Procedural Terminology* (CPT) in billing EPSDT covered screenings. The CPT Manual may be obtained by calling the American Medical Association at 1-900-621-8335. The Health Insurance Claim Form, CMS-1500 (08-05) must be used to bill for screening services and immunizations. The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician Manual*. Locators 24D and 24H are specific to EPSDT screening claims. **The appropriate procedure modifier is required in locator 24D for each CPT code for screenings. The appropriate indicator "1" is required in locator 24H.**

Referral providers authorized by a child's PCP to provide treatment or other health services to that child must enter the **Medicaid Provider Identification Number of the PCP in Locator 17a** of the CMS-1500 (08-05) in order to be reimbursed. Subsequent referrals resulting from the PCP's initial referral will also require the PCP's authorization and the PCP's Medicaid provider number in this block.

For children enrolled in MCOs, the MCO is responsible for payment of EPSDT screening services.

Billing for Developmental Screenings

Assessment and screening is a reimbursable service when a standardized screening tool is used. Providers may bill for a developmental screening or assessment, using the Current Procedural Terminology (CPT) code 96110, (E&M) visit when Modifier 25 is used along with the appropriate E&M code (CPT codes 99201-215 and 99381-395) for that visit.

Providers may use the following modifiers, when appropriate as defined by the most recent (CPT). The member's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service, and tool used that allowed the use of the modifier.

- Modifier 22 – Unusual Procedural Service: When the service provided is greater than that usually required for the procedure code. Use of this modifier will cause the claim to pend for manual review and requires an attachment to explain the use of the modifier. Physicians should not apply this modifier unless there are unusual situations that warrant manual review.
- Modifier 24 – Unrelated E&M Service by the same Physician during the post-operative period.
- Modifier 25 – Significant, separately identifiable E&M Service on the same day by the same Physician on the same day of the procedure or other services.
- Modifier 59 – Distinct Procedural Service

This section describes how to claim an EPSDT periodic screening or well-child visit and when to bill for an inter-periodic or problem focused visit in lieu of a well child visit. A list of the Current Procedural Terminology (CPT) codes used to reimburse for well child visit services is included in the "Exhibits" section of this chapter.

Screening/Well Child Billing Guidance

- **Complete Well Child/EPSDT Screening (CPT 99381-99395):** Bill the appropriate evaluation and management (E&M) code for Preventive Medicine Services (screening) when **all services** included in the procedure code as described in the Current Procedural Technology (CPT) manual are completed and documented. Use the ICD diagnosis codes for a “healthy visit.”
- **Incomplete EPSDT Screening (CPT 99381-99395):** If screening is incomplete because the child is uncooperative, bill the E&M code for an appropriate office visit and reschedule the child for the next appropriate EPSDT screening/well child visit. Use the ICD diagnosis code that defines the child’s health status for this “problem focused” visit.
- **Problem Focused or Inter-periodic Screening “Sick Visit” (99201-99215):** These are problem-focused screenings that are used to investigate specific health complaints and to refer children for any type of medical or mental health treatment. Use the ICD diagnosis code that defines the child’s health status for this visit. The screening provider may not bill for a separate office visit for treatment of the child’s illness or condition on the date a complete screening is billed.

Billing for Hearing, Vision, and Developmental Screenings During the EPSDT Well Child or Problem Focused Visit

Objective hearing screening (CPT code 92551), vision screening (CPT code 99173), and developmental assessment (CPT code 96110) procedures performed using a standardized screening method on the same date of service as a Preventive Medicine E&M will be reimbursed separately when Modifier 25 is used along with the appropriate E&M code for that visit.

Use the following modifiers, when appropriate as defined by the most recent Current Procedural Terminology (CPT). The member’s medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier.

- **Modifier 22 – Unusual Procedural Service:** When the service provided is greater than that usually required for the procedure code. Use of this modifier will cause the claim to pend for manual review and requires an attachment to explain the use of the modifier. Physicians should not apply this modifier unless there are unusual situations that warrant manual review.
- **Modifier 24 – Unrelated E&M Service by the same Physician during the post-operative period.**

- Modifier 25 – Significant, separately identifiable E&M Service on the same day by the same Physician on the same day of the procedure or other services.
- Modifier 59 – Distinct Procedural Service

Billing for Special or Inter-periodic EPSDT Screenings (Medicaid Fee-for-Service Providers)

- **Missed Screenings** - If a child misses a regular periodic screening, that child may be screened at the earliest possible time to bring the child into compliance with the AAP-recommended periodicity schedule. Providers should follow billing instructions for an EPSDT/Well Child screening.
- **Inter-periodic Screenings** - Screenings may be provided in addition to the regular periodicity schedule screenings for medical evaluation of a specific problem. Inter-periodic screenings may be billed as a sick visit however, it cannot be used to provide a school, Head Start or sports physical when a well child visit was provided earlier that year. If a screening is needed to examine a specific issue or complete a developmental or comprehensive history related to a specific medical issue, then an inter-periodic screening can be provided using the appropriate preventive medicine codes. Any caregiver, medical provider or a qualified health, developmental, or educational professional who comes in contact with the child outside of the formal health care system may request that an evaluative inter-periodic screening be performed. These screenings require a brief narrative justifying the additional inter-periodic screen in the medical record. Providers should submit inter-periodic preventive and objective screening claims with a **22** Modifier to the procedure code, attach the justification statement to the claim and write “**Attachment**” in **Locator 10D** of the CMS 1500 claim form for proper processing.
- **School Entry, Headstart, and Sports Physicals** - Headstart/school entry and participation in athletics often create opportunities to screen children who are not current for Well Child/EPSDT screenings. If the child is **not** current with the Well Child/EPSDT schedule, complete the age appropriate Well Child/EPSDT screen. If the child is current with the Well Child/EPSDT schedule, a request for a Headstart/School Entry or Sports Physical does not justify the need for an inter-periodic medical screening. Providers may document the Well Child/EPSDT screening based on the School Entrance physical forms. However the physical exam is not a covered service when the child is current with his or her well child visit schedule.

Billing for Laboratory Tests

The screening provider may bill separately for laboratory tests that are performed as part of

the screening and documented in the child's medical record. DMAS will only reimburse the provider actually performing the service (i.e., physician, independent laboratory, or other facility). The screening provider may bill for incurred handling and shipping charges on the HCFA-1500 (12-90) when the specimens are sent to an outside laboratory.

Lead Testing Claims Process

A list of lead testing procedure codes is included in the "EPSDT Screening Procedure Codes" exhibit at the end of this chapter. When lead testing is provided during a well child visit or other health care encounter, the EPSDT screener must use the lead testing procedure codes with a "25" modifier in block 24D of the CMS-1500 Claim Form. Independent Laboratories or EPSDT screeners that have an approved laboratory will bill the 83655 code when the lead test is performed.

If blood lead screening tests are conducted in the provider's offices, the code 83655 for Lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site.

A comprehensive list of Medicaid-enrolled lab providers may be found by contacting the DMAS Provider HELPLINE, or by accessing the DMAS web portal at <http://www.dmas.virginia.gov/#/maternalepsdt>.

When blood lead testing is provided to a client enrolled in a Virginia Medicaid Managed Care Organization (MCO), the provider should follow the MCOs specific billing instructions. Providers should always verify Medicaid eligibility before services are rendered. DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility. The web portal to enroll for access to this system is:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

VFC or Immunization Billing Questions

For questions relating specifically to the VFC program vaccines, contact the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday

through Friday from 7:00 a.m. to 5:00 p.m. For billing questions, contact the Medicaid Provider Help Line at 1-800-552-8627.

Office Visits Billed in Conjunction with Immunizations

DMAS will reimburse physicians an appropriate minimal office visit in addition to the VFC administration fee (or acquisition cost for adolescents ages 19 and 20 only) when an immunization is the only service performed.

EPSDT REFERRALS FOR SPECIALIZED SERVICES

When an EPSDT screening indicates the need for diagnosis or treatment for a suspected condition or abnormality, the physicians' progress notes must so indicate. The child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment. If the screening provider is not the child's PCP, the screening provider must contact the child's PCP to request a referral and authorization for the treatment or other services.

The PCP must follow up on all EPSDT referrals resulting from a screening to ensure that the child receives the requested treatment or other services within 60 days and document the results in the child's medical record.

The Omnibus Budget Reconciliation Act of 1989 requires states to reimburse for medically necessary services not otherwise covered under the *State Plan* for Medicaid-eligible children up to the age of 21 when such services are needed to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services, as long as the services are allowable under the *Social Security Act* 1905(a) and are authorized by DMAS or its contractors

Some services are available outside of the *State Plan* under *Social Security Act* Section 1915(c) through Home and Community-Based Services Waivers. Services covered under Section 1915(c) are not covered under EPSDT unless they are also allowable services under Section 1905(a). For more information on Home and Community-Based Waivers, providers may contact the DMAS Provider Call Center at 1-800-552-8627 or refer to

<http://www.dmas.virginia.gov/#/ltss>

SERVICE AUTHORIZATION FOR SPECIALIZED SERVICES

Any treatment service that is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its contractor as medically necessary. Treatment services that are approved through the EPSDT benefit but are not available through the State Plan for Medical Assistance are called EPSDT Specialized Services.

Reimbursement for EPSDT specialized services is limited to the hours of treatment and medical or clinical supervision as specified in the treatment plan and as approved by DMAS or its contractors. All specialized service requests require physician documentation outlining the medical necessity, frequency and duration of the treatment. To qualify for reimbursement through the EPSDT benefit EPSDT specialized services must be approved before the service is rendered by the provider. Please see Appendix A to this supplement for additional information.

Detailed information on the service authorization of behavioral therapy, nursing, personal care inpatient services and audiology and hearing aid services defined as "Specialized Services" under EPSDT is available in separate EPSDT chapters and Appendix A available on the DMAS web portal at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>. DMAS or its contractor service authorizes other services through the EPSDT benefit such as Residential Treatment for persons with developmental and behavioral challenges, hospital based services to treat neurological conditions, bariatric related treatment, treatment for eating disorders and treatment for other chronic health conditions. The services available through EPSDT are not limited to those listed. Please see Appendix A for additional information.

Chiropractic Services

Chiropractic services are available for Medicaid members under the age of 21 and through the DMAS EPSDT benefit. This service cannot be authorized for Medicaid members age 21 and older. Chiropractors (Provider Type 026) are the only providers to submit these requests. DMAS or its contractor will apply McKesson InterQual® to certain services and DMAS criteria where McKesson InterQual® products do not exist. If unable to approve a request, then DMAS or its contractor will apply EPSDT criteria. The Chiropractic CPT codes requiring service authorization are listed below.

Chiropractic CPT codes to submit for service authorization:

98940 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

98941 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, THREE TO FOUR REGIONS

98942 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, FIVE REGIONS

98943 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, ONE OR MORE REGION

Please see Appendix A for additional service authorization information.

Review of Items Denied Under DME for Coverage through EPSDT

In addition to the traditional review of requests for Durable Medical Equipment and Supplies (DME), children enrolled in either FAMIS Plus and FAMIS Fee for Service who are initially denied services under the DME program will receive a secondary review for these items using the EPSDT “correct or ameliorate” approval criteria. Some of these services will be approved by the DMAS service authorization contractor under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some may be referred to DMAS by its contractor on a case-by-case basis. Specific information regarding the methods of submission for children enrolled in FFS may be found at the contractor’s website, <https://dmas.kepro.com/>. The contractor may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. Providers should contact the MCO for DME requests for children enrolled in managed care.

For additional information on the service authorization of DME, please see Appendix D of the DME Provider Manual. A copy of this manual is available on the DMAS Medicaid web portal.

Service Authorization Status:

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, service authorization, and pharmacy prescriber identification. The DMAS web portal to enroll for access to this system is <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

ASSISTIVE TECHNOLOGY

To correct or ameliorate physical or mental conditions identified during EPSDT screening services, the child may be referred by the EPSDT screener or PCP for Assistive Technology services. Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the *Virginia State Plan for Medical Assistance*. Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable.

To meet the definition of Assistive Technology, requested items must meet all of the following requirements. Assistive Technology must:

- be able to withstand repeated use;
- be primarily and customarily used to serve a medical purpose and be medically necessary and reasonable for the treatment of the individual's disability or to improve a physical or mental condition;
- generally be not useful to a person in the absence of a disability, physical or mental condition; and
- be appropriate for use in both the home and community.

Equipment or supplies already covered by the *Virginia State Plan for Medical Assistance* may not be requested for reimbursement under EPSDT. A list of covered items is located in the Durable Medical Equipment and Supplies Provider Manual that is available on the DMAS website at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>. Providers may use the "Medicaid DME and Supplies Listing" located in Appendix B of this manual to ascertain whether an item is covered through the *Virginia State Plan for Medical Assistance* before requesting the item through EPSDT. Equipment and supplies must be provided by a DME provider or assistive technology provider.

Criteria

Only Assistive Technology items that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS. Assistive Technology must be:

- Ordered by a physician to correct or ameliorate physical or mental conditions identified during EPSDT screening services;
- A reasonable and medically necessary part of a treatment plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
- Not furnished solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- Provided at a safe, effective, and cost-effective level that is suitable for use by the individual.

Assistive Technology must involve direct support to the individual and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. Therefore, services that do not involve direct support to the individual or environmental services dealing exclusively with an individual's surroundings rather than the individual are not covered. Further, even if the requested service does involve some direct support for the individual, it cannot be covered unless the device is related to the diagnosis given as the reason for the service request.

Home/Environmental modifications do not meet the definition of Assistive Technology and are not covered under EPSDT services. Environmental modifications are defined as physical adaptations to an individual's home, primary place of residence, vehicle, or workplace. Examples of environmental modifications include but are not limited to devices that are permanently affixed to the walls of the home such as grab bars, ramps, barrier free lifts, and widening of doorways.

Individuals and caregivers are responsible for determining if the individual is receiving the appropriate Assistive Technology in the school system and suggesting that the child's Individualized Education Plan (IEP) include Assistive Technology. In cases where Assistive

Technology is requested for use during school hours and not included in the IEP, the provider must obtain documentation from the school indicating why the Assistive Technology is not included in the child's IEP. Items covered under the Individuals with Disabilities Education Act (IDEA) cannot be covered under EPSDT. For information regarding Medicaid covered school services, please see the School Health Services Manual located on the DMAS website at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

Service Authorization Requirements

All Assistive Technology items must be authorized by DMAS or its contractor. Service authorization for children enrolled in Managed Care must be obtained through the MCO. Please see Appendix A for additional information. Each Assistive Technology item must be recommended and determined appropriate to meet the individual's needs by a qualified professional such as an occupational therapist, physical therapist, speech language pathologist or behavioral consultant.

Medical documentation must provide a clear understanding of the individual's needs. Documentation for each requested Assistive Technology item must identify:

- The medical need for the requested Assistive Technology;
- The diagnosis related to the reason for the Assistive Technology request;
- The individual's functional limitation and its relationship to the requested Assistive Technology item;
- How the Assistive Technology item will treat the individual's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- The frequency of use;
- The estimated length of use of the item;
- Any conjunctive treatment related to the use of the item;
- How the needs were previously met and identifying changes that have occurred which necessitate the Assistive Technology request;
- Other alternatives tried or explored and a description of the success or failure of these alternatives;
- How the Assistive Technology item is required in the individual's home or community environment; and
- The individual's or caregiver's ability, willingness, and motivation to use the Assistive Technology item.

Provider Documentation Requirements

Documentation requirements include:

1. Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, and materials.
2. Written documentation which proves that the item was requested and was not approved by the *Virginia State Plan for Medical Assistance* as Durable Medical Equipment and Supplies;
3. Documentation of the date services are rendered and the amount of service needed;
4. Any other relevant information regarding the device or modification;
5. Documentation of the satisfaction of the individual and/or the individual's family with the service
6. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed. and
7. The individual's or caregiver's ability to use the Assistive Technology item effectively.

Specific information regarding the methods of submission for individuals enrolled in FFS are found at the contractor's website, <https://dmas.kepro.com/> The contractor may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. All authorizations should be submitted prior to the first date services are rendered or prior to the last day of the current authorization in order for submissions to be timely and to avoid any gaps in service.

For additional information on the service authorization process, please refer to Appendix A to this Supplement.

MEDICAL FORMULA COVERED AS DURABLE MEDICAL EQUIPMENT (DME)

The Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit allows the Virginia Department of Medical Assistance Services (DMAS) to provide medically necessary formula and medical foods to EPSDT eligible children under the age of 21 based on medical

necessity. The current DMAS Durable Medical Equipment (DME) provider manual defines EPSDT formula approval criteria in Chapter 4 of that manual. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under physician direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Medical formula and nutritional supplements must be physician recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. Enrollees under the age of five may receive medical formula and nutritional supplements through either a local Women, Infants and Children (WIC) office or a DMAS enrolled DME provider. If the individual is enrolled in the WIC program, they also receive nutrition education services and checkups as well as referrals to other services that can help the family. Individuals enrolled in Medicaid may already financially qualify for WIC. When a local WIC office provides the formula for children under the age of five then the WIC program forms are used to document medical necessity. Please refer to the DME provider manual for additional information.

OTHER RELATED PROGRAMS

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods and provides nutrition counseling to pregnant, postpartum, or breastfeeding women and children under age five with nutritional and financial needs. PCPs and EPSDT screening providers must refer Medicaid-eligible individuals in these categories to the local health department for additional information and eligibility determination.

Head Start

Head Start is a federally funded pre-school program which serves low-income children and their families.

There are four major components in Head Start as follows:

- Education¾Head Start's educational program is designed to meet the individual needs of each child. It also aims to meet the needs of the community served and its ethnic and cultural characteristics;
- Health¾Head Start emphasizes the importance of early identification of health

problems. Since many children of low-income families have never seen a doctor or dentist, Head Start provides every child with a comprehensive health care program, including medical, dental, mental health, and nutritional services. The comprehensive EPSDT screening will meet the requirements of the Head Start Program health assessment;

- **Parent Involvement**^{3/4}Parents are the most important influence on a child's development. Parents are encouraged to participate in the Head Start program as volunteers or paid staff as aides to teachers and other staff members. Many parents serve as members of Policy Councils and committees and have a voice in administrative and managerial decisions;
- **Social Services**^{3/4}The social services component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build upon the individual strengths of families to meet those needs. Some of the activities that the social services staff use to assist families to meet their needs are: community outreach; referrals; family needs assessments; providing information about available community resources and how to obtain and use them; recruitment and enrollment of the children; and emergency assistance and/or crisis intervention.

Early Intervention Program

Early intervention services are identified in the Part C amendment to the Individuals with Disabilities Education Act (IDEA). Part C provides for a discretionary grant program for states to plan, develop and implement a statewide, comprehensive, coordinated, interagency system of early intervention services to infants and toddlers with disabilities and their families.

Infant & Toddler Connection of Virginia/DMAS Early Intervention Program

The Infant & Toddler Connection of Virginia assists families of infants and toddlers with developmental delays and/or disabilities to help their children learn and develop through everyday activities and routines so that they can participate fully in family and community activities. Since there are no income limits for this program, all children who meet the early intervention eligibility criteria and who are under the age of three are eligible to receive early intervention services. In order to take advantage of the services and supports available, families need to know about the system and how to access these resources. More information can be found about the Infant & Toddler Connection of Virginia at: <http://www.infantva.org/>

Who is eligible for the Infant and & Toddler Connection of Virginia?

Infants and toddlers with 25% or greater delay in one or more developmental area(s):

Cognitive, adaptive, receptive or expressive language, social/emotional, fine motor, gross

motor vision, hearing development

Infants and toddlers with atypical development - as demonstrated by atypical/questionable:

Sensory-motor responses, social-emotional development, or behaviors, or impairment in social interaction and communication skills along with restricted and repetitive behaviors

Infants and toddlers with a diagnosed physical or mental condition that has a high

probability of resulting in developmental delay:

e.g., cerebral palsy, Down syndrome or other chromosomal abnormalities, central nervous system disorders, effects of toxic exposure, failure to thrive, etc.

Instructions about how to refer children to the Infant and & Toddler Connection may be found online at: <http://www.infantva.org/documents/pr-ReferralGuide.pdf>

The referral form for the Infant & Toddler Connection is attached to this document and it can be found online at: <http://www.infantva.org/documents/forms/3094eEI.pdf>

For more information, contact:

Infant & Toddler Connection of Virginia

DBHDS, 9th Floor

1220 Bank Street

PO Box 1797

Richmond, Va. 23218-1797

(804)786-3710

(804)371-7959 Fax

www.infantva.org

Smart Beginnings

Virginia's Plan for Smart Beginnings brings together the public agencies, private agencies and organizations that support Virginia's children and families to ensure that these efforts are both effective and well coordinated. The purpose of Virginia's Plan for Smart Beginnings is to build and sustain a system in Virginia to support parents and families as they prepare their children to arrive at kindergarten healthy and ready to succeed. More information regarding this program can be found at www.smartbeginnings.org.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation or contract is approved by the MCOs, Behavioral Health Services Administrator (BHSA), a DMAS contracted Medicare and Medicaid Plan (MMP) or DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited", "moderate" or "high". Please refer to the table in the Exhibits of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements

for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre- and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every five years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers who are enrolling with DMAS or the BHSA and meet the provider types indicated in the Appendix of this Chapter are required to pay an application fee set forth in Section 1866(j)(2)(C) of the Social Security Act and 42 CFR 455.460. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. Providers shall refer to the specific MCOs and MMPs for any additional requirements. The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship

request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, MMP, the BHSA or DMAS. Providers will receive written instructions from the MCOs, MMPs, the BHSA or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, MMPs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members, the provider must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Providers approved for participation in the MCOs, MMPs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify DMAS, the MCOs, MMPs and the BHSA in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify DMAS, the MCOs, MMPs and the BHSA prior to the change and include the effective date of the change; Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS, the MCOs, MMPs and the BHSA require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.
- Use the MCOs, MMPs, BHSA and DMAS designated methods for submission of charges;
- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;
- Assure the individual's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;
- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;
- Charge the MCOs, MMPs, BHSA and DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;
- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a “State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency”. The provider should not attempt to collect from the individual or the individual’s responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses \$5.00 of an \$8.00 charge, and Medicaid’s allowance is \$5.00, the provider may not attempt to collect the \$3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge the MCOs, MMPs, BHSA, DMAS or an individual for broken or missed appointments;
- Accept assignment of Medicare benefits for dual eligible Medicaid enrolled individuals;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Reimburse the individual or any other party for any monies contributed toward the individual’s care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided; In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members; and
- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public.
- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid members.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with federal regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered,

or prescribed by excluded individuals or entities. Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the person or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded person or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to the contracted MCOs, MMPs and the BHSA any exclusion information discovered. Such information should also be sent in writing and should include the person or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Suite 1300

Richmond, VA 23219

E-mail to: providerexclusions@dmass.virginia.gov

APPEALS

Individual's Right to Appeal and Fair Hearing

The Code of Federal Regulations at 42 CFR §431 *et seq.*, and the Virginia Administrative

Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the individual. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the individual will be expected to repay DMAS for all services received during the appeal period. For this reason, the individual may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The individual or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street, 11th floor

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. Documents received after 5:00 p.m. on the deadline date shall be untimely.

Provider Appeals of Adverse Actions

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take

whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Provider Reconsiderations and Appeals (MCO and FFS)

Non-State Operated Provider

For services that have been rendered, providers have the right to appeal adverse actions. However, before appealing to the Department, providers must first exhaust any MCO's or DMAS Contractor's reconsideration process. Providers in an MCO's network may not appeal enrollment or terminations decisions made by the MCO to the DMAS Appeals Division. Providers enrolled with DMAS through the DMAS Contractor may appeal enrollment or termination decisions made by the DMAS Contractor to DMAS once they have exhausted the reconsideration process with the DMAS Contractor.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 *et. seq.* and 12 VAC 30-20-500 *et. seq.*

All provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or the MCO's or DMAS Contractor's adverse reconsideration decision. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within 30 calendar days of receipt of the MCO's or DMAS Contractor's reconsideration decision shall result in an administrative dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division



Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. shall be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date shall be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision shall result in dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq.* and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

EXHIBITS

Please use this link to search for DMAS Forms:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch>

TABLE OF CONTENTS

Virginia EPSDT Periodicity Chart	1
EPSDT Screening Procedure Codes	2
Provider Risk Category Table	3

EPSDT SCREENING PROCEDURE CODES

DESCRIPTION Code	Age	CPT
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INITIAL SCREENINGS

NEWBORN CARE (outpatient)	Normal newborn care	99432
NEW PATIENT	less than 1 year of age	99381*
NEW PATIENT	1-4 years of age	99382*++
NEW PATIENT	5-11 years of age	99383*
NEW PATIENT	12-17 years of age	99384*
NEW PATIENT	18-20 years of age	99385*

PERIODIC SCREENINGS

ESTABLISHED PATIENT	less than 1 year of age	99391*
ESTABLISHED PATIENT	1-4 years of age	99392*++
ESTABLISHED PATIENT	5-11 years of age	99393*
ESTABLISHED PATIENT	12-17 years of age	99394*
ESTABLISHED PATIENT	18-20 years of age	99395*

DEVELOPMENTAL TESTING (Instrument, Interpretation/Report)

SCREENING	0-20	96110
EXTENDED	0-20	96111

LEAD TESTING (Mandatory at 12 mos. and 24 mos. of age)

TESTING	0-20	83655
COLLECTION VENOUS SAMPLE	0-20	36415
COLLECTION CAPILLARY SAMPLE	0-20	36416
SPECIMEN HANDLING	0-20	99000

VISION SCREENINGS

VISION	3-20 years of age	99173
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HEARING SCREENING

HEARING	0-20 years	92551
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Use of the appropriate CPT modifiers on the claim should be indicated as previously defined within this chapter or CPT.

**Use appropriate Immunization Codes for scheduled immunizations*

++ Lead Testing required at 12 and 24 months

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes (Y) or No (N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(Inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate - Revalidating High - Newly Enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate - Revalidating High - Newly Enrolling	Y
Home Health Agency - Private Owned	Moderate - Revalidating High - Newly Enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate - Revalidating High - Newly Enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate - Revalidating High - Newly Enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Moderate - Revalidating High - Newly Enrolling	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N

EPSDT Personal Care Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services

The Virginia Medicaid Program covers Personal Care for eligible individuals through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). This chapter provides details of EPSDT Personal Care including the definition of the service, individual eligibility requirements, provider requirements and the service authorization process.

EPSDT Personal Care services are available to Medicaid/FAMIS Plus members under 21 years of age and fee for service FAMIS members under the age of 19 who meet medical necessity criteria for the service.

The EPSDT program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. Federal law (42 CFR § 441.50 et. Seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment becomes costlier. Examination and treatment services are provided at no cost to the individual.

Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to a Medicaid eligible individual through EPSDT even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance may be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS, its service authorization contractor or a DMAS-contracted managed care organization (MCO) to be medically necessary. Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account a particular child's needs.

EPSDT Personal Care Services are designed to assist children under the age of 21 who meet

the criteria for EPSDT Personal Care as defined in this supplement with activities of daily living (ADLs), instrumental activities of daily living (IADLs), medically necessary supervision and monitoring of self-administered medications. From the Centers for Medicare and Medicaid Services (CMS) publication *EPSDT: A Guide to States*, "The determination of whether a child needs personal care services must be based upon the child's individual needs and provided in accordance with a plan of treatment or service plan...The determination of whether a child needs personal care services must be based upon the child's individual needs and a consideration of family resources that are actually - not hypothetically - available." DMAS has established criteria for EPSDT Personal Care but each request must be individually reviewed based on the medical needs of the particular child and his or her family's ability to meet those needs.

CMS also provided special guidance to states on services for children with Autism Spectrum Disorders in 2014. States must assure that families of children with Autism Spectrum and other Developmental Disorders, including Intellectual Disabilities (previously referred to as Mental Retardation), are aware of and have access to a broad range of services to meet the individual child's needs. EPSDT Personal Care is one of these services.

Some individuals with a diagnosis of intellectual disabilities, autism and other, developmental disabilities, and individuals with behavioral health diagnoses may have active treatment needs that cannot be met exclusively by EPSDT Personal Care services. These individuals who meet the criteria for EPSDT Personal care may still receive EPSDT Personal Care services, however, community based services may be suggested to address the individual's other treatment needs. Referrals should be made to appropriate community based care services such as the Commonwealth Coordinated Care (CCC) Plus Waiver (formerly known as the Elderly or Disabled with Consumer Direction (EDCD) Waiver), the Community Living (CL) Waiver, the Family and Individual Support (FIS) Waiver as well as other community mental health rehabilitation services that may be necessary to promote appropriate community based health care for each individual.

EPSDT Personal Care may not be authorized when the individual presents with needs that do not necessitate Personal Care services consisting of ADL supports. Each request for EPSDT Personal Care services will be reviewed on an individualized basis by DMAS or its contractor.

DEFINITIONS

Agency-Directed Personal Care Services – Personal care services provided by an agency chosen by the individual. The agency handles all of the employment components for the individual such as hiring and firing of the Personal Care assistant. The agency bills DMAS or its contractor for services provided.

Activities of Daily Living (ADLs) – Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers the Medicare, Medicaid, and State Child Health Insurance (FAMIS) programs.

Community Setting – Services provided within the everyday routines and activities in which families participate, and in places where the family would typically be so that their daily life is supported. A community setting is one that would be considered a natural or normal place for a child or adolescent without disabilities to spend time alone, with peers, or with adults (related or not), e.g. child care setting, public library, shopping mall, restaurant.

Consumer-Directed Personal Care Services – Personal care services provided by an assistant chosen by the individual. The individual or individual's representative handles all of the employment components for the individual such as hiring and firing of the Personal Care assistant with the assistance of a Service Facilitation Provider. DMAS or its contractor reimburses the Personal Care assistant for services received.

Dependency – The need for assistance from someone else to perform a Personal Care task. Assistance can include hands on care, prompting, verbal cueing, multiple reminders and/or supervision.

EPSDT Screener - DMAS enrolled Physician, Physician Assistant, or Nurse Practitioner.

Instrumental Activities of Daily Living (IADLs) - Life activities including light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, assistance with self-administration of medication and money management.

Personal Care Services - Support services provided in the home and community settings necessary to maintain or improve an individual's current health status. Personal care services are defined as help with ADLs and IADLs, monitoring of self-administered medications, and the monitoring of health status and physical condition.

Person Centered Plan of Care (POC) - The document used to record the individual's service needs.

PROVIDER PARTICIPATION REQUIREMENTS

Agency-Directed Personal Care

The provider of services must be a home health organization licensed by the Virginia Department of Health (VDH) that has a current signed participation agreement with DMAS or a DMAS contracted managed care organization to provide Personal Care.

In addition to following requirements of the provider agreement, a Personal Care Agency must meet the following requirements:

Staffing Requirements

1. Registered Nurse (RN)

The provider must employ (or subcontract) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all personal care assistants and licensed practical nurses (LPN). The RN must possess the following qualifications:

- A license to practice in the Commonwealth of Virginia;
- At least one (1) year of related clinical experience as a RN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility;
- A satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adults or children is acceptable;
- The RN must submit to a criminal record check obtained through the Virginia State Police. If the individual receiving services is a minor, the RN must also submit to a search of the VDSS Child Protective (CPS) Central Registry. The provider must not hire any RN with findings of barrier crimes identified in 32.1-162.9:1 of the *Code of Virginia* or founded complaints in the CPS Central Registry; and
- Documentation of license, clinical experience, references, and evidence of a criminal background record check and central registry search if applicable must be maintained in the RN's personnel file for review by DMAS staff.

2. Personal Care Assistant

Each personal care assistant hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS and the agency's Virginia Department of Health (VDH) license. Basic qualifications for personal care assistants include:

- Physical ability to do the work;
- Age 18 years or older;
- Ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
- Ability to create and maintain required documentation;
- Have the required skills to perform the services;
- Have a valid social security number;
- Receive tuberculosis (TB) screening as specified in criteria used by the Virginia Department of Health <http://www.vdh.virginia.gov/TB/Policies/screening.htm#cand>;
- Meet one of the following qualifications:
 1. Have certification as a nurse aide issued by the Virginia Board of Nursing. A copy of the state certificate must be maintained in the assistant's personnel record. If the certification has expired and the assistant has not renewed the certification, the agency must contact the Board of Nursing to ensure that the assistant's certification was not revoked for disciplinary reasons and that the assistant meets one of the other DMAS requirements.

2. Have satisfactorily completed a nurse aide education program approved by the Virginia Board of Nursing. The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which offer certificates qualifying the student as a Nursing Assistant or Home Health Aide. If an assistant has successfully completed one of these Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, ensure that it is from a Board of Nursing-accredited institution, and maintain this documentation in the assistant's personnel file for review by DMAS staff.
3. Have satisfactorily completed a nursing education program preparing for registered nurse licensure or practical nurse licensure;
4. Be successfully enrolled in a nursing education program preparing for registered nurse or practical nurse licensure and have currently completed at least one nursing course that includes clinical experience involving direct client care; or
5. Have satisfactorily passed a competency evaluation program that meets the criteria of 42 CFR 484.36 (b). Personal care assistants need only be evaluated on the tasks in 42 CFR 484.36 (b) as those tasks relate to the personal care services to be provided.

Regardless of the method of training received, documentation must be present indicating the training was received prior to assigning an assistant to provide services for an individual. Based on continuing evaluations of the assistant's performance and the individual's needs, the RN Supervisor shall identify any significant gaps in the assistant's ability to function competently and shall provide the necessary training.

- In addition to the initial training requirements for personal care assistants, each assistant must have a minimum of 12 hours of training annually. This training is provided by the provider agency and must be related to the performance of personal care services. Documentation of this training must be kept in the employee's personnel files. DBHDS offers trainings for direct support professionals who work with children with intellectual and development disabilities. These trainings are

available on the DBHDS website, www.dbhds.virginia.gov.

- The provider should verify all information on the employment application prior to hiring a personal care assistant. The assistant must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. If the assistant has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable. If possible, obtain references from the educational facility, vocational school, or institution where the assistant's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the assistant (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff.
- Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The personal care assistant must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider **shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.**
- The provider must have documentation proving that a criminal background check and CPS Central Registry check, if applicable, was obtained. This documentation must be made available to DMAS staff upon request.

3. Licensed Practical Nurse (LPN)

Each LPN hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Basic qualifications for LPNs include:

- The LPN must be able to practice in the Commonwealth of Virginia;

- Have at least one (1) year of related clinical experience as a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility.
- A satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the LPN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.
- Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The LPN must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider **shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.**
- The provider must have documentation proving that a criminal background check and CPS Central Registry check, if applicable, was obtained. This documentation must be made available to DMAS staff upon request.
- If possible, references should be obtained from the educational facility, vocational school, or institution where the LPN received training. Documentation of the date of the reference check, the individual contacted and their relationship to the LPN (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS or its contractor. Personal care service providers may be related to an individual, but may not be the parents (biological, step parent, adoptive, legal guardian) of children less than 18 years of age or the individual's spouse. Payment may not be made for services furnished by other family members unless there is objective written documentation

as to why there are no other providers available to provide the care. Family members who provide personal assistance services must meet the same standards as providers who are unrelated to the individual and must be employed by an agency.

Consumer-Directed Personal Care

A participating Consumer-Directed (CD) Service Facilitator (SF) is a facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed Participation Agreement with DMAS or DMAS contracted managed care organization.

Service facilitation agencies provide supportive services designed to assist eligible individuals with the hiring, training, supervising, and firing responsibilities of Personal Care assistants, who perform basic health-related services. Any provider contracting with Medicaid to provide Service Facilitation services agrees to adhere to all of the policies and procedures as described in the provider agreement and this manual.

CD Services Facilitator (SF) Requirements

The CD Services Facilitator (SF) provides ongoing supervision of the individual's Person Centered Plan of Care. The SF must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the SF's application form, found in supporting documentation, or observed during the interview and maintain in the employee's personnel file.

Observations during the interview must be documented. The knowledge, skills, and abilities shall include, but are not necessarily limited to:

1. Knowledge of:

- Types of functional limitations and health problems that are common to individuals with disabilities, as well as strategies to reduce limitations and health problems;
- Child development and developmental disabilities;
- Physical assistance typically required by people who have physical and developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;
- Equipment and environmental modifications that are commonly used and required by people who have physical and developmental disabilities which reduce the need for human assistance and improve safety;
- Various long-term care program requirements, including nursing facility level of care criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance and respite services;
- Various behavioral health program requirements;
- DMAS consumer-directed personal care program requirements, as well as the administrative duties for which the individual will be responsible;
- Conducting assessments (including environmental, psychosocial, and functional factors) and their uses in care planning;
- Interviewing techniques;
- The individual's right to make decisions about, direct the provisions of, and control his or her services, including hiring, training, managing, approving time sheets, and firing a personal care assistant;

- The principles of human behavior and interpersonal relationships; and
- General principles of record documentation.

2. Skills in:

- Negotiating with individuals and service providers;
- Observing, recording, and reporting behaviors;
- Identifying, developing, and providing services to individuals who have disabilities; and
- Identifying services within the established services system to meet the individual's needs.

3. Ability to:

- Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have print impairments;
- Demonstrate a positive regard for individuals and their families;
- Be persistent and remain objective;
- Work independently, performing position duties under general supervision;

- Communicate effectively both orally and in writing; and
- Develop a rapport and communicate with different types of persons from diverse cultural backgrounds

DMAS offers a training program for Service Facilitators. This training covers all of the key responsibilities of being a services facilitator. This training is available at; <http://www.vcu.edu/partnership/servicesfacilitators/index.html>. Service Facilitators must complete required training and competency assessments and maintain satisfactory competency assessment results in the personnel record.

Documentation of a required degree or license and previous satisfactory experience must be maintained in the provider's personnel file for review by DMAS staff. There must also be documentation of positive work history as evidenced by at least two satisfactory reference checks recorded in the SF's personnel file including no evidence of abuse, neglect, exploitation of incapacitated older adults or children.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The SF must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

If the SF is not a RN, the provider must inform the individual's primary health care provider that services are being provided and request consultation as needed. A lapse in qualified SF availability may require that the provider subcontract with another SF provider until appropriate staff can be hired. If the provider is unable to provide services for a period of 30 days, the provider should notify individuals and provide choice of a new SF provider. When the individual has chosen a new provider the SF should transfer the individual's services and immediately notify the service authorization entity.

Employer of Record

Individuals choosing to receive services through the CD model may do so by choosing a SF to provide the training and guidance needed to be an employer. As the employer, the individual is responsible for hiring, training, supervising, and firing attendants. The individual may choose to designate a person to serve as the employer on his/her behalf. The individual or the chosen designee is the Employer of Record (EOR). If the individual is under 18 years of age the parent or responsible adult must serve as the EOR. A person serving as the EOR cannot be the paid caregiver, attendant, or SF. An EOR can only serve on behalf of one individual. The only exception to this is that EORs can serve on behalf of multiple individuals only if the individuals reside at the same address.

It is the individual's responsibility to hire, train, supervise, and, if necessary, fire the Personal Care assistant. Each Personal Care assistant hired by the individual must be evaluated by the individual to ensure compliance with the minimum qualifications as required by DMAS.

Specific duties of the individual or EOR, as the employer of the CD personal care assistant, include checking references, determining that the employee meets basic qualifications, submitting required hiring documentation to the fiscal employer agent (F/EA), training, supervising performance, and submitting time sheets to the F/EA on a consistent and timely basis. CD attendants are not eligible for Worker's Compensation.

The inability to obtain and retain Personal Care assistants can be a serious threat to the safety and health of an individual. If an individual is consistently (over a 30-day period) unable to hire and retain the employment of a Personal Care assistant, the CD Service Facilitator should talk to the individual about Agency Directed Personal Care services.

CD Personal Care Assistant Requirements

It is the individual's or their chosen Employer of Record's (EOR) responsibility to hire, train, supervise, and, if necessary, fire the Personal Care assistant. The EOR is considered the employer and can be the individual or someone chosen by the individual to represent them. Each Personal Care assistant hired by the EOR must be evaluated by the individual to ensure compliance with the minimum qualifications as required by DMAS. Basic

qualifications for Personal Care assistants include:

- Being 18 years of age or older;
- Being able to read and write in English and possess basic math skills to the degree necessary to perform the tasks expected;
- Having the required skills to perform care as specified in the individual's Person Centered Plan of Care;
- Possessing a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for assistants that care for minor children. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. The Personal Care assistant will not be compensated for services provided to the individual once the records check verifies the Personal Care assistant has been convicted of any of the crimes that are described in § 32.1-162.9:1 or § 37.2-416 of the Code of Virginia.;
- Willingness to attend or receive training at the EOR's/family's/individual's request;
- Understanding and agreeing to comply with the CD Personal Care services program requirements; and,
- Receive periodic tuberculosis (TB) screening as specified in criteria used by the Virginia Department of Health
<http://www.vdh.virginia.gov/TB/Policies/screening.htm#cand>

A personal care assistant cannot be the parent (biological, step parent, adoptive, legal guardian) of the minor child or spouse of the individual receiving personal care services. Payment may be made for services rendered by other family members or caregivers living under the same roof as the individual receiving personal care services only when there is written, objective documentation as to why no other assistant is able to provide services for the individual. The family member or caregiver providing personal care services must meet the same requirements as other personal care assistants. In addition, anyone who has legal guardianship for the individual shall also be prohibited from being a personal care assistant under this program. Personal care assistants are prohibited from also serving as the EOR for the individual receiving personal care services.

The EOR should verify information on the application form prior to hiring a Personal Care assistant. It is important that the qualifications are met by each Personal Care assistant to ensure the individual's health and safety. These qualifications must be documented by the EOR and maintained by the CD Service Facilitator for review by DMAS staff.

CD Service Facilitators are not responsible for finding Personal Care assistants for the individual, however, they are required to support the individual by providing hiring resources. CD Service Facilitators are also not responsible for verifying Personal Care assistants' qualifications. This is the EOR's responsibility.

Provider Enrollment

All providers who wish to participate with Virginia Medicaid should enroll through the online enrollment system available on the Virginia's Medicaid web-portal at: www.virginiamedicaid.dmas.virginia.gov. Providers can also download a paper application from the Virginia Medicaid web-portal.

For assistance with the online or paper enrollment process, please contact Xerox Provider Enrollment Services at 1-888-829-5373.

For children whose EPSDT Personal Care is service authorized by a Medicaid MCO, providers should contact the MCO for provider enrollment information.

ELIGIBILITY CRITERIA

EPSDT Personal Care services are available to currently enrolled Medicaid or FAMIS Plus members under the age of 21 years and FAMIS Fee for Service members under the age of 19 who meet medical necessity criteria for Personal Care services. Medicaid or FAMIS Plus members enrolled in Medicaid Managed Care Organizations (MCOs) are eligible to receive EPSDT Personal Care Services. Children enrolled in FAMIS MCOs do not have the EPSDT Personal Care benefit and are not eligible for EPSDT Personal Care. Children enrolled in FAMIS MCOs who have personal care needs should contact the local Department of Social Services (DSS) to inquire about the application process for the Commonwealth Coordinated Care (CCC) Plus Waiver, formerly known as the Elderly or Disabled with Consumer Direction (EDCD) Waiver.

Personal Care available through Home and Community Based Waivers

In addition to the CCC Plus Waiver, personal care is also available through the Community Living (CL) Waiver and Family and Individual Support (FIS) Waiver administered through the Department of Behavioral Health and Developmental Services (DBHDS). Current CMS guidelines require that individuals under age 21 enrolled in a Home and Community Based Waiver who meet medical necessity for personal care services receive the service through EPSDT Personal Care instead of the waiver program.

Effective 8/1/2017, DBHDS will apply EPSDT criteria when completing personal care service authorizations for children on the FIS and CL Waivers. Children currently receiving personal care services through the CCC Plus Waiver will begin receiving personal care under EPSDT criteria after transitioning to CCC Plus as discussed in the next section.

Medicaid Managed Care

Consistent with Virginia General Assembly and Medicaid reform initiatives, DMAS is moving

forward transitioning individuals from fee-for-service models into managed care. Beginning August 1, 2017, EPSDT Personal Care will be included as part of the managed care services depending on the managed care program in which the child is enrolled.

Managed Care Program	Coverage for EPSDT Personal Care
Medallion 3.0	Carved out, not covered by MCO. Service authorized by DMAS or its contractor*
CCC Plus (effective 8/1/17)	Covered and service authorized by MCO.*
FAMIS MCO	No coverage for EPSDT Personal Care

**EPSDT Personal Care for children enrolled in the CL and FIS Waivers is carved out of the CCC Plus contract. EPSDT personal care is service authorized by DBHDS for all children enrolled in the CL and FIS Waivers (FFS, Medallion 3.0 and CCC Plus).*

Children enrolled in Medallion 3.0

For children enrolled in Medallion 3.0, EPSDT Personal Care services are carved out from the services provided by a DMAS contracted MCOs. **MCOs with a Medallion 3.0 contract are not required to cover Personal Care services for Medicaid/FAMIS Plus members.** Individuals enrolled in a MCO with a Medallion 3.0 contract access EPSDT Personal Care services by following the process outlined in the Service Initiation Section of this chapter.

Children Enrolled in Commonwealth Coordinated Care Plus (CCC Plus)

CCC Plus is a new statewide Medicaid managed care program beginning August 1, 2017. CCC Plus will serve individuals with complex care needs, including children enrolled in Home and Community Based Waivers, through an integrated delivery model that includes

medical services, behavioral health services and long-term services and supports. Children enrolled in CCC Plus, with the exception of those children enrolled in the CL and FIS Waivers, will receive EPSDT Personal Care Services through the MCO. Providers and families should contact the MCO for information on obtaining service authorization for EPSDT Personal Care. Contact information for CCC Plus MCOs is located at http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Medical Necessity

Health conditions (medical and/or behavioral health), which include Autism spectrum and other Developmental Disorders, must cause the individual to be functionally limited in performing three or more activities of daily living (ADL). These categories are bathing, dressing, transfers, ambulation, eating/feeding, toileting, and continence. Requiring prompting, verbal cueing, multiple reminders or supervision during an ADL is considered a dependency in that ADL for EPSDT related requests. For example, a child with autism may need step by step prompts to complete an ADL successfully. The need for prompting would qualify the child as dependent with that ADL.

The child's need for assistance with ADLs due to a health condition must be documented by the child's primary care provider on the EPSDT Functional Status Assessment Form (DMAS-7). The form must be completed and signed by a physician, physician's assistant or nurse practitioner and updated every year.

Service Requests for Young Children

The individual's inability to perform activities of daily living cannot be exclusively due to age. The functional deficits resulting from normal attainment of developmental milestones are not subject to EPSDT treatment because these functional deficits are not due to a health or mental health condition. By signing the DMAS-7, the primary care provider attests that the care needs are related to a health condition and not due to functional limitations associated with the normal attainment of developmental milestones.

Chapter IV of the DMAS Pre-Admission Screening Manual provides detailed criteria for determining when a child can be considered dependent with ADLs by age and should be used as a resource when DMAS or its service authorization contractor is considering

whether an ADL dependency is exclusively due to age or is also related to a health condition. For example, a child younger than 12 months should be totally dependent on another person for bathing. However, a child under the age of 12 months who has characteristics that make bathing very difficult (hypertonia, spastic involuntary movement, sensory/cognitive issues, etc..) can meet the ADL criteria for EPSDT Personal Care because his or her dependency with bathing is not exclusively due to age.

Medically Necessary Supervision in EPSDT Personal Care and Attendant Care:

EPSDT allows supervision hours when it is medically necessary for the member to receive supervision due to a health condition. Disruptive behaviors such as aggression, self-injury, elopement/wandering, impulsivity, property destruction, etc. may require constant supervision from a personal care assistant to maintain the child's safety in addition to the hours required for ADL/IADL supports. The behaviors must be documented on the DMAS-7.

If there is clear, objective documentation as to why the caregiver in the home is unable to provide adequate supervision required to maintain the child's safety then the medically necessary supervision may be provided in the home while parents or caregivers are present. For example, a parent is the sole caregiver available and there are multiple children in addition to the member in the home during the time the supervision hours are being requested. When a child has such extensive behavioral challenges it may be wise to refer the child for other services such as EPSDT Behavioral Therapy and/or other relevant behavioral health services. Children with extensive behavioral challenges who meet EPSDT Personal care criteria may receive Personal Care services as part of the overall Person Centered Plan of Care.

COVERED SERVICES AND LIMITATIONS

The Following Services Are Covered:

1. Assistance with ADLs: bathing, dressing, toileting, transferring, eating/feeding, ambulation and bowel and bladder continence. Assistance can include hands on care, prompting, verbal cueing, multiple reminders and/or supervision.
2. Assistance with IADLs related to the individual such as light housework, laundry,

meal preparation, transportation, grocery shopping, using the telephone, and money management.

3. Medically Necessary Supervision related to a health condition.
4. Special Maintenance tasks including monitoring health status and physical conditions; assistance with self-administration of medication (not to include in any way determining the dosage or the direct administration of medication) and other tasks such as range of motion, wound care and bowel programs as allowed in accordance with the Virginia Administrative Code 18VAC90-20-420 et.seq. Delegation of Nursing Tasks and Procedures and the Code of Virginia § 54.1-3001(12).

The unit of service for Personal Care services is one hour. Payment is available only for allowable activities that are service authorized and provided by a qualified provider in accordance with an approved Person Centered Plan of Care (POC) and EPSDT program criteria.

EPSDT Personal Care services are service authorized based on the hours and ADL support services documented in the Person Centered Plan of Care (DMAS-7A) and the provider's assessment (DMAS-99). Each EPSDT POC must be completed by either a Registered Nurse or CD Services Facilitator. If ADL or IADL hours are deemed excessive, the child's behaviors may be considered if these behaviors directly impact the ability to complete the ADL and IADL tasks.

Services can be provided in both the home and the community in which the child participates. Whether a child can receive the service along with another Medicaid funded service is dependent on the criteria of the other service. For example, with appropriate documentation, a child can receive EPSDT personal care simultaneously with EPSDT Behavioral Therapy as personal care is not a required component of EPSDT Behavioral Therapy.

The individual must have a realistic and viable back-up plan, such as a family member, neighbor, or friend who is willing and able to assist the individual on very short notice in case the Personal Care assistant does not show up for work as expected. This backup plan must be in writing and must be part of the individual's case record at the agency providing care or maintained by the Service Facilitation provider. The Personal Care or Services Facilitation provider is not responsible for providing back-up assistance. The provider is not

responsible for contacting the person identified on the back-up plan; this is the responsibility of the individual/family. Individuals who do not have a back-up plan are not eligible for services until a viable, written backup plan is identified and included in the individual's record.

EPSDT Personal Care Services at School

EPSDT Personal Care Services, including Medically Necessary Supervision, may be provided in a school setting if the service is not included in the member's Individualized Education Program (IEP) and the services are deemed medically necessary. Providers must document the medical need for coverage in the school setting and document that the service is not included in the member's IEP. Personal care hours used during the school day, if authorized by the service authorization entity, count toward the total number of hours allowed based on the individual's daily need for care.

The Following Services Are *Not* Covered:

1. General Supervision
2. Respite
3. Performance of tasks for the sole purpose of assisting with the completion of a member's job requirements.
4. Assistance provided in hospitals, other institutions, assisted living facilities, and licensed group homes.

SERVICE INITIATION

The individual/guardian or case manager with consent from the individual/guardian may request that an EPSDT screener (physician, physician assistant or nurse practitioner) complete the EPSDT Functional Assessment Form (DMAS-7). The screener may bill for an inter-periodic screening if the screening is in excess of the periodicity schedule. The EPSDT screener forwards the completed DMAS-7 to the selected Personal Care agency or CD Service Facilitator.

Individuals may receive Personal Care through an agency-directed or consumer-directed

model of care. The model of care is chosen by the individual or the caregiver if the individual is not able to make a choice. This choice must be made freely without interference from the provider or CD Service Facilitator. For children enrolled in FFS, Medallion 3.0 or the CL and FIS Waivers, a list of available personal care providers and CD Services Facilitators is available through the provider search on the DMAS Web Portal, www.virginiamedicaid.dmas.virginia.gov/wps/portal. Personal care services for children enrolled in CCC Plus, with the exception of those children enrolled in the CL and FIS Waivers, are coordinated by the MCO and the MCO should be contacted for list of available personal care agencies and CD service facilitators.

Development of the Person Centered Plan of Care (DMAS-7A)

Upon receipt of a completed DMAS-7 and before the delivery of services, the CD Services Facilitator or Personal Care Agency must conduct an assessment. The CD Service Facilitator or Personal Care Agency should consult with the individual's primary health care provider as necessary during the assessment and development of a Person Centered Plan of Care.

The Person Centered Plan of Care (DMAS-7A) must be completed by the personal care provider's RN or CD Service Facilitator prior to the start of care for any individual. The EPSDT Functional Assessment form (DMAS-7) indicates the personal care needs of the individual. Time does not need to be allocated for each of the tasks on the Person Centered Plan of Care; these may be checked or a description given, if necessary. Each service category should be totaled if time has been allotted to that category (ADLs, Special Maintenance, Medically Necessary Supervision, and IADLs).

There are situations in which the individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). The provider must complete two plans of care, labeled morning or afternoon, to indicate each shift of services.

The provider is responsible for making modifications to the Person Centered Plan of Care as needed to ensure that the assistant and individual (or family) is aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual. Any time the number of hours for an individual need to be changed, the provider must develop a new Person Centered Plan of Care reflecting the revised hours and submit the request for service authorization. The most recent Person Centered Plan of Care must always be in the individual's home. These plans of care and documentation of service delivery must be consistent with the information submitted for service authorization.

SERVICE AUTHORIZATION REQUIREMENTS

All services must be service authorized. The service authorization entity varies depending on the managed care and/or waiver program in which the child is enrolled.

Program	Service Authorization Entity
FFS*	Service authorized by DMAS or its contractor.
Medallion 3.0*	Service authorized by DMAS or its contractor.
CCC Plus (effective 8/1/17)*	Service authorized by MCO, contact the MCO for service authorization information.
CL and FIS Waivers	Service authorized by DBHDS effective 8/1/17.

* with the exception of those children enrolled in the CL and FIS Waivers

Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided.

For information regarding the service authorization submission process for FFS and Medallion 3.0, refer to the EPSDT Appendix A.

SERVICE AND DOCUMENTATION REQUIREMENTS

Agency-Directed Model

Individuals may choose agency directed services and select a personal care agency to provide their services. Once an agency has accepted the referral, services must be initiated by the RN Supervisor.

Initial Assessment Visit

The RN Supervisor must make an initial assessment visit on or before the start of care. An assessment visit must also be made when an individual is re-admitted after discharge from services or upon transfer from another provider. During this visit, the RN Supervisor must conduct and document the following activities:

- Review with the individual/family the needs identified by the EPSDT Screener as documented on the EPSDT Personal Care Functional Status Assessment (DMAS-7);
- Complete the Community-Based Care Individual Assessment Report (DMAS-99) based on the needs identified by the individual/family;
- Identify with the individual or family/caregiver, all individual needs to be addressed in the Person Centered Plan of Care (DMAS - 7-A) and develop a safe, appropriate Person Centered Plan of Care that will meet the identified needs of the individual;
- Review the Person Centered Plan of Care with the individual/family to ensure that there is complete understanding of the services that will be provided;
- Discuss and determine the appropriate frequency of supervisory visits with the individual/family and document the discussion to include the individual's/family's choice on the DMAS 99. The determination of supervisory visit frequency must be based on the individual's needs. The minimum frequency of these visits is every 90 calendar days;
- Prior to the start of services, introduce the assistant to be assigned to the individual. Each regularly assigned assistant must be introduced to the individual by the RN Supervisor, or other staff (this may be done by telephone) and oriented to the individual's Person Centered Plan of Care prior to the assistant's start of care for that individual. The RN/LPN Supervisor must closely monitor every situation when a new assistant is assigned to an individual so that any difficulties or questions are dealt with promptly;

Follow-up Visit

It is recommended that the RN/LPN Supervisor conduct a follow-up visit within 30 calendar days of the initial visit to assess the individual's needs and to make a determination as to whether the Person Centered Plan of Care sufficiently meets the individual's needs. The date of this visit must be documented on the DMAS 99.

RN/LPN Supervisory Visits

The RN/LPN Supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services and to supervise personal care assistants. The minimum frequency of these visits is every 90 calendar days.

During the RN/LPN Supervisory visit, the RN/LPN must determine if the Person Centered Plan of Care continues to meet the individual's needs, and document the review of the plan. If it does not, then a new Person Centered Plan of Care must be developed and if a change in the amount of hours is needed, the RN/LPN must submit the request to the service authorization entity for review.

A RN/LPN Supervisor must be available to the assistants by telephone at all times that an assistant is providing services to an individual. A provider may contract with a RN to provide this service. Ongoing assessment of the assistant's performance by the RN/LPN Supervisor is also expected to ensure the health, safety, and welfare of the individual.

If the supervising RN/LPN is unable to conduct the regular supervisory visit within required timeframes, it shall be documented in the individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the individual's first availability.

Based on continuing evaluations of the assistant's performance and the individual's needs, the RN/LPN Supervisor shall identify any gaps in the assistant's ability to function competently and shall provide training as necessary. The RN/LPN Supervisor must also perform any subsequent evaluations or changes to the supporting documentation.

RN Supervisory Visits

The RN Supervisor must conduct a review of home visits the LPN Supervisor's performance

as well as to assess the on-going needs of the individual and services received. The RN Supervisor must identify any gaps in the LPN's supervisor's ability to function competently and shall provide training as appropriate.

Documentation Requirements – Agency Directed EPSDT Personal Care

The provider shall maintain a record for each individual. These records must be separated from records related to other services, such as companion services or home health.

The individual file must include the following:

- All EPSDT Personal Care Functional Status Assessment (DMAS-7);
- All provider Plans of Care (DMAS-7-A) fully signed and dated by the RN;
- All Community Based Care Recipient Assessment Report (DMAS 99) fully signed and dated by the RN/LPN Supervisor;
- Aide Records (DMAS-90);
- All RN/LPN Supervisor notes. The RN/LPN Supervisor notes must:
 - be completed as agreed upon by the individual/family;
 - be filed within two weeks of the supervisory visit;
 - document whether the assistant was present. The assistant must be present at a minimum of every other RN/LPN Supervisor visit;
 - document family satisfaction with services. The RN/LPN supervisor must document private conversations with the family to assess satisfaction with services at a minimum of every other month (either in person without the assistant present or by telephone during times the assistant is not in the home if the assistant is always present during the Supervisory visit);
 - document, using the DMAS-99, observations of the individual made during the visits as well as any instruction, supervision, or counseling provided to the assistant working with the individual;
 - document that the appropriateness and adequacy of the service based on the individual's current functioning has been discussed with the individual/family;
 - Include a RN/LPN Supervisor summary which notes:
 - any change in the individual's medical condition, functional status, and social support;
 - whether the individual continues to meet EPSDT personal care criteria;
 - whether the Person Centered Plan of Care is adequate to meet the individual's needs or if changes need to be made;
 - dates of any lapse of service and why (e.g., hospitalization admission and

- discharge dates, assistant not available, etc.);
- the presence or absence of the assistant in the home during the visit; and
- any other services received by the individual;
- All provider contacts with the individual and others related to the individuals such as contacts with family members/caregivers, health professionals, formal and informal service providers, the service authorization contractor, DMAS, etc. All notes must be signed and dated and filed in the individual's records within two (2) weeks from the date of the contact;
- Copies of documentation entered by direct data entry that is submitted electronically via the service authorization entity's portal system;
- Documentation that the assistant's records were reviewed;
- Documentation of overall monitoring of the ongoing provision of services which includes:
 - The quality of care provided by the assistant, LPN (when utilized) and the RN;
 - The functional and medical needs of the individual and any modification necessary to the Person Centered Plan of Care due to a change in these needs; and
 - The individual's need for support in addition to care provided by personal care assistant.

Assistant Responsibilities/Required Documentation: Agency-Directed (AD) Model

The assistant is responsible for following the Person Centered Plan of Care, notifying the RN Supervisor of any change in condition, support, or problem that arises and documenting the performance of duties on the Aide Record (DMAS-90). The DMAS-90 must be completed on the day the service was delivered. The DMAS-90 is designed to contain one calendar week of service provision. Agencies may not, in any way, make changes to the DMAS-90.

Documentation on the DMAS-90 must include:

- the specific services delivered to the individual by the assistant;
- the assistant's actual daily arrival and departure times;
- the assistant's weekly comments or observations about the individual, including the individual's physical and emotional condition, daily activities, and responses to services rendered, and;
- any other information appropriate and relevant to the individual's care and need for services;

- the personal care assistant's and individual's/family's weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless he is a family/caregiver of the individual. This family member cannot be the same family member who is providing the service. In instances where the individual is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. If the individual is unable to sign his/her signature on the DMAS-90 the individual may make an "X". The RN Supervisor must document on the DMAS 99 that the "individual is unable to sign the DMAS-90."

Documentation on the DMAS-90 must be in the English language. Signatures, times and dates must not be placed on the personal care assistant's record prior to the last date that the services are actually delivered. The aide record sheets must be in the individual's record within two (2) weeks. Corrections to any form in the record must be made by drawing a line through the incorrect entry, then re-entered, initialed and dated with the correct information. Correction fluids (white-out) must never be used for correction. Copies of all documents are subject to review by state and federal Medicaid staff or representatives. It is the responsibility of the provider to ensure that the DMAS-90 are delivered to the provider and filed in the individual's record within two (2) weeks. A periodic review of the DMAS-90 must be done prior to filing it in the individual's record to ensure that the RN Supervisor is aware of any changes in the individual's needs or any changes in the Person Centered Plan of Care, which may be indicated by the assistant's documentation on the DMAS-90. An accurately signed and dated DMAS-90 is the only authorized documentation of services provided for which DMAS will reimburse. DMAS will not accept employee payroll time sheets in place of the DMAS-90.

Electronic Visit Verification (EVV)

Personal care agencies choosing to utilize HIPAA compliant EVV systems may do so by using a system that records and contains the same elements as the DMAS 90 and permits the system to verify the location from which the services are provided and the individual for whom the services are provided.

The EVV shall: 1. Ensure daily back-up for all data collected; 2. Protect data securely and reliably; 3. Demonstrate a disaster recovery mechanism allowing for use within twelve hours

of disruption to services (subject to exceptional circumstances such as war and other disasters of national scope); and 4. Be capable of producing reports of all services and supports rendered, the individual's identity, the start and end time of the provision of services and supports and the date/s of service in summary fashion that constitute documentation of service that is fully compliant with regulation.

Each personal care assistant and individual/family receiving services will have a unique personal identification number or a biometric identification system. The personal care assistant shall not be able to enter or modify the time and date. The unique identification system shall constitute the necessary electronic signatures for services. No additional electronic or wet signatures shall be required.

Billing for Agency Directed Personal Care and Respite Services Under EVV, Effective October 1, 2019.

Beginning October 1, 2019, DMAS will no longer accept paper claims (CMS-1500) or direct data entry (DDE) claims for agency directed personal care and respite services. All agency providers submitting procedure codes associated with EVV must submit electronic EDI claims in the 837-P X12 standard. Should a provider submit claims for these services on paper, or via DDE, the claim will deny. The following link provides access to the 837 Professional Health Care Claims and Encounter Transactions Companion Guide:

https://www.dmas.virginia.gov/files/links/1157/MES_EPS_837P_Companion_Guide

Each of the following six (6) data elements must be captured for EVV:

1. The type of service(s) performed – service procedure code
2. The individual receiving the services – member's Medicaid ID
3. The date of the service
4. The location of the service delivery – This is a physical address, city, state and zip code and not geographical coordinates. Two (2) locations will be captured, the beginning location and the ending location.
5. The individual providing the service – the aides first and last name, and a unique ID of the aide, which is generally an employee ID associated with the agency submitting the claim.

6. The time the service began and ended – this will be in the military format, 00:00 – 23.59

If any of these fields are not completed or incomplete on the 837P, the claim will deny with one or more of the following edits, which will be enabled, effective October 1, 2019:

1. Beginning Location Address, City, State, Zip Code must be present
2. Ending Location Address, City, State and Zip Code must be present
3. Attendant/Aides Last Name, First Name, and unique ID must be present
4. Time Service Begin – must be in valid 24-hour military time format
5. Time Service Ended – must be valid 24-hour military time format and after the begin time, either later in the same day, or the next day.

EVV will not be required for services in Department of Behavioral Health and Developmental Services (DBHDS) licensed facilities, such as a group home, sponsored residential home, supervised living, supported living or similar licensed facility, the REACH Program, or in a school setting. These agency providers must use a modifier of UB in association with the agency directed service procedure code when submitting their claim.

Consumer-Directed (CD) Model

Individuals choosing to receive services through the CD model may do so by choosing a SF to provide the training and guidance needed to be an employer.

Service Facilitation Comprehensive Visit

The SF initiates services with the individual upon accepting the DMAS-7 from the EPSDT screener. The SF must make an initial comprehensive home visit prior to the start of care by a personal care assistant. During the visit, the SF will work with the individual/family to identify all support needs of the individual to be addressed in the Person Centered Plan of Care. Based on the information discussed and together with the individual/family, the SF

will develop a safe, appropriate Person Centered Plan of Care that will meet the identified needs of the individual. The initial comprehensive visit is done only once upon the individual's entry into the service. If an individual changes SFs or the individual subsequently adds another CD service, the new provider must conduct and bill for a reassessment visit in lieu of a comprehensive visit.

Consumer (Individual) Training

The SF, using the Employer of Record Manual must provide the individual/EOR with training on the responsibilities as an employer within seven days of the completion of the comprehensive visit (SFs may complete the comprehensive visit and individual training in the same day, if appropriate). To assure that the training content for Employee Management Training meets the acceptable requirements, the SF must use the DMAS EOR Manual found on the DMAS website at www.dmas.virginia.gov. The SF must also follow the checklist outlined in the Consumer-Directed Individual Comprehensive Training Form (DMAS-488). This is an outline of the subjects that DMAS requires the SF to cover during the training. The SF must check each subject on the form after it has been covered, and obtain the required signatures and dates. This form must be maintained in the individual's file and be available for review by DMAS staff or DMAS contracted entity. The SF will ensure that the individual/EOR understands his/her rights and responsibilities in the program and signs all of the Participation Agreements including the DMAS-486 and DMAS-489. These forms must be signed before the individual can begin employing an assistant in the program. The SF should also provide assistance in filling out employer forms in the Employer of Record Welcome Packet that is received from the FEA.

NOTE: This training is for the employer of the assistant. The SF must not offer training of any type to the assistant.

Routine On-site Visits

After the comprehensive visit, SF conducts two in-home routine visits within 60 calendar days of the comprehensive visit (once every 30 calendar days) to monitor the individual/EOR's ability to hire and maintain assistants, to monitor the individual's Person Centered Plan of Care and assess both the quality and appropriateness of the services being provided. After the first two routine in-home visits, the SF and individual can decide how frequent the routine on-site visits will be however, a face-to-face meeting with the individual must be conducted at least every 90 days. The SF must review the individual's status, make any needed adjustments to the Person Centered Plan of Care, and provide any necessary information to the individual and record all significant contacts in the individual's file.

If the SF is unable to make a visit due to inclement weather or the individual is not available, the

SF must document on a progress note in the individual's record the reason for the delay in the visit and document when the next visit will occur. Such routine on site visits shall be conducted within 15 calendar days of the individual's first availability.

During visits with the individual, the SF must observe, evaluate, and consult with the individual/EOR and family/caregiver as appropriate and document the adequacy and appropriateness of the CD services with regards to the individual's current functioning and cognitive status, medical and social needs, and the established Person Centered Plan of Care on the DMAS-99. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Person Centered Plan of Care continues to meet the individual's needs, and document the review of the plan.

If it does not, then a new Person Centered Plan of Care must be developed and if a change in the amount of hours is needed, the SF must submit the request for service authorization.

The SF's documentation of this visit must include:

- Whether CD services are adequate to meet the individual's needs and whether changes to the Person Centered Plan of Care need to be made;
- Any suspected abuse, neglect, or exploitation and to whom it was reported. This must be reported to the Virginia Department of Social Services; Adult Protective Services (APS) or Child Protective services (CPS), as appropriate.
- Hospitalization or change in medical condition, functioning, cognitive status, or social support;
- The individual's or family's /caregiver's (as appropriate) satisfaction with services;
- The presence or absence of the attendant in the home during the visit;
- Any change in who is employed as the attendant. The F/EA cannot pay for any services until a completed packet is received for each employee;
- Dates of and reasons for any service lapses (hospitalization admission, attendant not available, etc.); and
- In addition to the information that must be documented in the SF's routine visit summary, there are several areas (such as bowel/bladder programs, range of motion

exercises, catheter and wound care, etc.) that, when they are part of an individual's Person Centered Plan of Care due to physician's orders, require monitoring by the individual's primary health care professional or a RN and special documentation by the SF of their ongoing completion and the personal care assistant's qualifications to perform these tasks.

Verification of Time Sheets: The SF shall review copies of the time sheets quarterly or more frequently as appropriate to ensure that the hours of service provided are consistent with the Person Centered Plan of Care. Timesheets may be viewed on the F/EA web portal. If the individual, acting as the employer, is unable to sign the time sheet, the individual may make an "X" or a family/caregiver may sign on his behalf. If the individual is unable to sign or make an "X," the SF must make a notation in the front of the individual's record that "individual is unable to sign." If discrepancies are identified in the time sheets in relation to the Person Centered Plan of Care, etc., the SF must contact the individual or EOR to resolve discrepancies. If there are consistently discrepancies in the time sheets and training has been offered to the individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).

Reassessment Visit

At least every six months, the SF must meet with the individual or family member/caregiver to conduct a reassessment of the individual's current functional and social support status and a complete summary of all services reviewed. Documentation of the reassessment visit must include a complete review of the individual's needs and available supports and a review of the Person Centered Plan of Care. The reassessment visit must be documented on a DMAS-99.

On-going Monitoring Activities

The SF is responsible for counseling an individual/EOR regarding the responsibilities as an employer; requesting service authorization changes based on the individual's Person Centered Plan of Care as needed; consulting with the individual/EOR or family member/caregiver as needed; and discussing with the individual the need for additional community based services. The SF must be available by telephone to individuals receiving CD services during normal business hours, have voice mail capability, and return phone calls within 1 business day. The SF is not responsible for supervision of personal care assistants and has no authority in hiring/firing assistants. The EOR is solely responsible for attendant supervision.

If the SF determines that the health, safety, or welfare of the individual may be in jeopardy, the

SF is responsible for making the appropriate referrals that may include APS/CPS, or if the person

is unable to self-direct services a referral to an agency directed service provider may be appropriate.

Management Training

Management training is provided by the SF upon the request of the individual/EOR during an on-site visit. This training is designed to assist the individual/EOR in understanding employer related activities. Management training must not be used to train the attendant.

Management training can also be used to reimburse the SF for the costs of tuberculosis screening, cardiopulmonary resuscitation certification (CPR), and annual flu immunizations for assistants. The SF can bill DMAS for the costs of these requirements on behalf of the individual by billing for these costs in management training units and maintaining documentation of these costs in the individual's file.

Individuals have the right to choose, hire, and employ an assistant whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code of Virginia

(32.1-162.9:1), as may be amended from time to time. When doing so, individuals and family members/caregivers must understand this decision and that the consequences thereof are their sole responsibility. The Individual/Employer Acceptance of Responsibility for Employment form must be completed and submitted to the F/EA.

CD Services and Fiscal/Employer Agent (F/EA) Functions

The F/EA performs payroll activities on behalf of the EOR. DMAS contracts with the F/EA to ensure that payment to the attendant is based on the approved service authorization which

documents the number of hours and services and time sheets approved by the EOR. Time worked by attendants is paid based on 15 minute units. The F/EA keeps payment records, and follows all tax rules on the EOR's behalf.

The SF or F/EA will provide a packet of employment information and necessary forms to the individual/EOR. The forms must be completed and returned to the F/EA before the attendant can be employed. The F/EA will handle responsibilities for the individual for paying the attendant and the related employment taxes. The F/EA will process all necessary employer related forms with the Internal Revenue Services in order to complete these duties.

The F/EA performs required criminal record checks for all assistants. When an assistant is providing services to an individual under 18 years of age the F/EA will screen assistants through the DSS CPS Central Registry. The F/EA will provide the individual/EOR with the results of the criminal record request and/or the CPS check and document in the individual's F/EA record that the individual or family member/caregiver has been informed of the results of the criminal record or CPS registry check. If the attendant has been convicted of crimes described in 12 VAC 30-90-180, or if the registry confirms a founded complaint on the assistant, the assistant will no longer be reimbursed under this program for services provided to the individual effective the date the individual or EOR was notified of the criminal record/CPS registry finding.

Documentation Requirements - Consumer-Directed (CD) Model

Documentation must clearly indicate the dates and times of CD services delivery (i.e., time sheets).

The SF must maintain records for each individual served. These records must be separated from those of any other services that may be provided by the SF/SF's employer. All documentation must be filed in the individual's record within two (2) weeks from the date of the visit/contact. The individual file must include the following:

- All EPSDT Personal Care Functional Status Assessment (DMAS-7) forms and any required service authorization documentation as detailed in the most current instructions for the DMAS-7;
- All provider Plans of Care (DMAS-7-A) fully signed and dated by the SF;

- All Community Based Care Recipient Assessment Report (DMAS 99) fully signed and dated by the SF. Only the DMAS-99 may be used for assessments/reassessments. The start date on the Person Centered Plan of Care will be the start date of service facilitation services for the individual;
- Copies of documentation entered by direct data entry that is submitted electronically via the service authorization entity's portal system;
- All provider contacts with the individual and others related to the individuals such as contacts with family members/caregivers, health professionals, formal and informal service providers, the service authorization entity's, DMAS, etc. All notes must be signed and dated and filed in the individual's records within two (2) weeks from the date of the contact;
- All management training provided to the individual/EOR or member/caregiver, including the individual's or family'/caregivers' responsibility for the accuracy of the attendant's time sheets;
- All documents signed by the individual or the family/caregiver that acknowledge the responsibilities for receipt of the services;
- If tasks are performed requiring nurse delegation, the RN's documentation of training, supervising, and all other related information and documentation must be maintained by the service facilitation provider.
- Documentation of the SF's assessment on the DMAS-99 which includes:
 - observations of the individual made during the visits.
 - any change in the previously documented individual's medical condition, functional status, and social support, which may require modifications to the Person Centered Plan of Care;
 - documentation the individual continues to meet EPSDT Personal Care criteria;
 - documentation that the Person Centered Plan of Care was reviewed with the individual/EOR and family/caregiver to determine if it is adequate to meet the individual's needs or if changes need to be made;
 - dates of any lapse of services and why (e.g., hospitalization, assistant not available, etc.);
 - documentation that the appropriateness and adequacy of services was discussed with the individual/family.
 - the presence or absence of the assistant in the home during the visit.
 - documentation of individual/EOR and family/caregiver satisfaction with the services; and,
 - any other services received by the individual.

All criteria and documentation requirements must be met for the entire time the service is provided in order to be reimbursed through EPSDT Personal Care.

DELEGATION OF SKILLED SERVICES

Personal care services shall not include either practical or professional nursing services as defined in the Nurse Practice Act with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18 VAC 90-20-420 et seq... The delegating RN is responsible for identifying and assessing if the personal care assistant is capable of performing the skilled nursing activity. If the RN delegates this activity to an assistant, the provider/SF must maintain the following documentation:

- The name of the RN, a copy of the RN's current license, and license number, and qualifications as stated earlier in this chapter;
- A description of the assessment conducted by the RN that includes the clinical status and stability of the individual's condition;
- The specific tasks that are to be delegated to the assistant;
- A description of the instruction given to the assistant, and confirmation by the RN that the assistant has been witnessed successfully giving the care;
- Review notes by the RN demonstrating the delegated activity is monitored and supervised by the RN at least every 90 calendar days, or more often if determined appropriate; and
- A current physician's order for the service(s). A new physician's order must be obtained every six (6) months or more frequently if changes in the individual's condition occur.

Exemption of Nurse Delegation Requirements

For CD services, The *Code of Virginia* § 54.1-3001(12) states "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements:

- Applies to consumer-directed services only
- Applies to tasks that are "typically" self-performed
- The individual receiving service must be capable of directing the attendant in the appropriate performance of the task.
- The individual must live in a private residence
- The individual must be unable to perform the tasks due to a disability

REIMBURSEMENT

EPSDT Personal Care Providers are reimbursed at the current payment rate used by the Home and Community Based Waivers.

EPSDT Nursing

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Private Duty Nursing Services

The Virginia Medicaid Program covers Private Duty Nursing for eligible individuals through the Early and Periodic Screening, Diagnosis and Treatment benefit (EPSDT). This chapter provides details of EPSDT Private Duty Nursing including the definition of the service, individual eligibility requirements, provider requirements and the service authorization process.

The EPSDT benefit is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. Federal law (42 CFR § 441.50 et seq.) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment becomes more costly. EPSDT is a Medicaid benefit and therefore there are no special enrollment procedures for members to access EPSDT services. Examination and treatment services are provided at no cost to the individual.

Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an eligible individual through EPSDT even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the

service is determined by DMAS, its service authorization contractor or a DMAS-contracted managed care organization (MCO) as medically necessary. Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account a particular child's needs.

EPSDT Private Duty Nursing services are available to Medicaid/FAMIS Plus members under 21 years of age and FAMIS members under the age of 19 who meet medical necessity criteria for the service. Private Duty Nursing may be provided to eligible persons who have demonstrated a medical need for nursing services according to the Nurse Practice Act. The Nurse Practice Act is defined in Chapter 30 of Title 54.1 of the Code of Virginia.

DEFINITIONS

Activities of Daily Living (ADLs): Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid, and State Child Health Insurance programs.

Commonwealth Coordinated Care (CCC) Plus Waiver: the CMS approved 1915 (c) home and community based services waiver that covers a range of community support services offered to individuals who meet the nursing facility or specialized nursing facility level of care. The CCC Plus waiver was previously known as the Elderly or Disabled with Consumer Direction (EDCD) Waiver and the Technology Assisted Waiver.

Congregate Private Duty Nursing: Private Duty nursing provided to two or more individuals who require Private Duty Nursing in the same home.

DMAS: The Virginia Department of Medical Assistance Services (DMAS) is the state Medicaid agency that is responsible for administering the Medicaid and CHIP programs.

EPSDT Screener: A DMAS enrolled or contracted Medicaid MCO enrolled Physician, Physician Assistant, or Nurse Practitioner.

FAMIS: Virginia's Children's Health Insurance Program (CHIP). FAMIS stands for Family Access to Medical Insurance Security. FAMIS is a separate federal program from Medicaid. FAMIS members are not eligible for Medicaid and are not eligible for certain EPSDT specialized services (Ex: Personal Care, and Residential Treatment) when enrolled in a FAMIS managed care organization.

Home: A place of temporary or permanent residence, not including a hospital, ICF/ID, nursing facility, or licensed residential care facility.

Home Health Certification and Plan of Care (POC): Physician certification to verify services are required. Private Duty Nursing providers may use the CMS-485 or another form that has the same information.

Home Health Nursing: Services provided by a certified home health agency on a part-time or intermittent basis to an individual in his/her place of residence. For Medicaid, the individual does not have to be home bound, but the services must be provided in the individual's home. Home health services provide skilled intervention with an emphasis on individual or caregiver teaching.

Instrumental Activities of Daily Living (IADLs): Life activities including light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, assistance with self-administration of medication and money management

Nurse Practice Act (NPA): Set of laws established by each state or territory to protect the public by regulating who can be a nurse, and what a nurse can do based on the level and content of his or her education. The NPA includes the education and licensing requirements and provisions for the nurse and disciplinary procedures and punitive measures for those who violate the NPA. The NPA is defined in Chapter 30 of Title 54.1 of the Code of Virginia.

Nursing: The performance of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health and the prevention of illness or disease. Nursing includes the supervision and teaching of those who are or will be involved in nursing care along with supervision and teaching the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board of Nursing. Nursing includes the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

Personal Care Services: Support services provided through EPSDT and home and community-based waivers that are necessary to maintain or improve an individual's current health status. Personal care services are defined as help with ADLs, Instrumental Activities of Daily Living (IADLs) related to the individual, monitoring of self-administered medications, and the monitoring of health status and physical condition.

Practical Nurse (L.P.N.): "Practical nurse" or "licensed practical nurse" means a person who is licensed or holds a multistate licensure privilege to practice practical nursing.

Practical Nursing: "Practical nursing" or "licensed practical nursing" means the performance of nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; in the prevention of illness or disease. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board of Nursing.

Private Duty Nursing (PDN): Individualized, medically necessary nursing care services consisting of skilled interventions, assessment, monitoring and teaching of those who are or will be involved in nursing care for the individual in order to correct, ameliorate or maintain the member's health condition. **As opposed to intermittent care provided under Skilled or Home Health Nursing, Private Duty Nursing is provided on a continuous and/or regularly scheduled basis according to medical necessity.** Private Duty Nursing does not include services used to specifically monitor medically controlled disorders or to provide only unskilled care. Private Duty Nursing care provided can be based in the individual's home or any setting in which normal life activities take place.

Private Duty Nursing Medical Needs Assessment (DMAS-62): A form summarizing the medical needs and used to determine the individual's medical necessity for nursing care on a daily basis. The DMAS-62 form must be completed by a physician, physician assistant, nurse practitioner, or registered nurse and signed/dated by a physician as documentation of need for Private Duty Nursing care.

Registered Nurse (R.N.): A person who is licensed or holds a multi-state licensure privilege to practice professional nursing as defined in the Nurse Practice Act.

School Based Nursing: Nursing care that is required in a school operated by the Local Education Agency or in a private school setting. Preschool, Head Start and daycare programs are not considered "school" settings since they are not operated by the Local Education Agency.

Service Authorization: The process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services.

Skilled Nursing: Nursing services that provide short-term intermittent skilled interventions with an emphasis on individual and caregiver teaching.

State Plan for Medical Assistance: The set of Medicaid benefits approved by the Commonwealth of Virginia and the Centers for Medicare and Medicaid Services (CMS).

Third Party Liability (TPL): Private or employer sponsored health insurance other than Medicaid or CHIP that is owned by the individual or purchased on the individual's behalf. This insurance may be liable for coverage of the requested service. TPL must be billed for nursing services prior to billing DMAS or its contracted MCOs.

Unskilled care: Level of care needed when the condition of the individual is medically stable and predictable, the needs described in the plan of care do not require the skills of a licensed nurse for medical care monitoring of a specific health condition.

PROVIDER PARTICIPATION REQUIREMENTS

Participating Private Duty Nursing Service Providers

A participating provider for Private Duty Nursing services must be licensed or certified as a home health agency by the Virginia Department of Health (VDH) and must have a current, signed agreement with DMAS or its contractor to provide Private Duty Nursing services. PDN providers for MCO members must be contracted with the specific MCO.

Parents(natural, step-parent, adoptive, foster parent, or other legal guardian), spouses, siblings, grandparents, grandchildren, adult children of, or any person living under the same roof with, the minor child who qualifies to receive Private Duty Nursing care will not be reimbursed by DMAS for providing nursing care to their children. Agencies may not employ a child's parent as the nurse assigned to provide nursing care to their child. Payment will only be made for services furnished by other family members if there is objective written documentation as to why no other providers are available to provide the care. Family members who provide Private Duty Nursing services must meet the same standards as nurses who are unrelated to the individual and must be employed by an agency.

Private Duty Nursing agencies provide professional nursing services to individuals in a home- or community-based setting. As discussed in the Service Initiation and Authorization section, DMAS, the MCO or DBHDS must authorize payment for Private Duty Nursing for individuals who have been assessed and determined to require PDN services in order to correct, ameliorate or maintain a health condition. Nurses employed by the Private Duty Nursing agency will administer medications, treatments, and care according to an authorized plan of care (CMS-485 or equivalent) which specifies the amount and type of care to be rendered. Private Duty Nursing must be provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) employed by a Private Duty Nursing provider enrolled with DMAS or a DMAS-contracted MCO.

PROVIDER ENROLLMENT

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through Virginia's Medicaid web-portal. If a provider is unable to enroll electronically through the website, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to www.viriniamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

If you have any questions regarding the online or paper enrollment process, please contact the Conduent Provider Enrollment Services at toll free 1-888-829-5373 or local 1-804-270-5105.

For children whose EPSDT Private Duty Nursing is service authorized by a Medicaid MCO, providers should contact the MCO for provider enrollment information.

Upon receipt of the above information, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application is **assigned to each approved provider. This number must be used on all claims and correspondence submitted to DMAS.**

NPIs may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share your NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

Instructions for billing and specific details concerning the EPSDT Private Duty Nursing Program are discussed in this manual. Providers must comply with all sections of this manual to maintain continuous participation in DMAS programs.

ELIGIBILITY CRITERIA

Children who are eligible for Medicaid/FAMIS Plus (under the age of 21), or FAMIS (up to

age 19) may receive Private Duty Nursing services. **Private Duty Nursing is available only to individuals who meet medical necessity criteria for Private Duty Nursing services.** Medical necessity for Private Duty Nursing must be documented during either a routine well-child visit, or during a screening for diagnosis or assessment of a specific medical or mental health condition. The DMAS-62 and Home Health Certification and Plan of Care (CMS-485) are required to document the need for Private Duty Nursing. The need for distinct monitoring and evaluative services must be documented in the provider's nursing POC; the need for medical monitoring must be documented in the comments section of the DMAS-62 Nursing Needs Assessment and must be documented in the nursing notes. The scope and duration of services will be determined on a case-by-case basis by reviewing the POC, the DMAS-62 and other supporting documentation provided by the physician and/or nursing company. Additional detail on documentation requirements for the DMAS-62, nursing Plan of Care are provided in the Service Initiation and Authorization section.

While children enrolled in FAMIS Plus with third party health insurance are eligible to receive coverage for Private Duty Nursing services, the third party insurance must be billed prior to billing DMAS. Below is a clarification of eligibility within the different programs and delivery systems.

Nursing and Community Based Care Medicaid Waivers

Although EPSDT services are not waiver services, EPSDT services may be provided to a child is enrolled in a Home and Community Based Care Waiver such as the Commonwealth Coordinated Care (CCC) Plus waiver Community Living (CL) Waiver and Family and Individual Support (FIS) Waiver. Current CMS guidelines require that individuals under age 21 who meet medical necessity for Private Duty Nursing services request services through EPSDT PDN. Effective 8/1/17, the Department of Behavioral Health and Disability Services (DBHDS) service authorizes EPSDT Private Duty Nursing for children enrolled in the FIS and CL Waivers, including children enrolled in Medallion 4.0 and CCC Plus Managed Care.

Children enrolled in Commonwealth Coordinated Care (CCC) Plus Managed Care

CCC Plus Managed Care is a statewide Medicaid managed care program. CCC Plus

Managed Care serves individuals with complex care needs, including children enrolled in Home and Community Based Waivers, through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports. Children enrolled in CCC Plus Managed Care, with the exception of those children enrolled in the CL and FIS Waivers, will receive EPSDT PDN, including eligible nursing in the school setting, through the MCO. Providers and families should contact the MCO for information on obtaining service authorization for EPSDT PDN.

Children enrolled in Medallion 4.0

Many Medicaid and FAMIS members receive primary and acute care through DMAS contracted managed care organizations (MCO) under the Medallion 4.0 Program. EPSDT Private Duty Nursing is service authorized by the Medallion 4.0 MCO for children enrolled in Medallion 4.0, with the following exceptions:

- School-based EPSDT Private Duty Nursing, when not included in a child's Individual Education Plan (IEP), is carved out of the Medallion 4.0 contract and service authorized by DMAS or its contractor.
- Children enrolled in the FIS and CL Waivers receive service authorizations for EPSDT PDN from DBHDS. This includes both school-based and home hours.

Providers should contact the MCO for information on accessing EPSDT Private Duty Nursing. Information for Providers on MCOs is located at <https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/> and <https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/>.

Family Access to Medical Insurance Security (FAMIS)

Most FAMIS benefits are administered through DMAS contracted MCOs. Benefits for FAMIS-Children under age 19 are administered through the Medallion 4.0 contracted MCOs. Providers should contact the MCO for information on accessing EPSDT Private Duty Nursing. A list of Medallion 4.0 MCOs is located at www.virginiamanagedcare.com.

FAMIS members who are not enrolled with a DMAS-contracted MCO receive services

directly through DMAS as a fee-for-service benefit.

COVERED SERVICES AND LIMITATIONS

Providers must employ an RN Supervisor who shall:

- Use and foster a person centered planning team approach to nursing services;
- Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;
- Ensure personal goals of the individual are respected;
- Conduct the initial evaluation visit to initiate EPSDT PDN services in the primary residence;
- Regularly evaluate the individual's status and nursing needs and notify the primary care provider if the individual no longer meets criteria for PDN;
- Complete the POC on the CMS-485 and update as necessary for revisions. The new POC should be sent to the service authorization entity at the beginning of each new certification period;
- Assure provision of those services requiring substantial and specialized nursing skill and that assigned nurses have the necessary licensure;
- Initiate appropriate preventive and rehabilitative nursing procedures;

- Perform an assessment, at least every 30 days (the monthly nursing assessment cannot be made by the nurse providing care in the home); RN Monthly Supervisory Visits shall be completed in the primary residence at least every other visit. Pediatric visits may be conducted in the school every other visit if necessary;
- Coordinate PDN services;
- Inform the physician and case manager as appropriate of changes in the individual's condition and needs;
- Educate the individual and family/caregiver in meeting nursing and related goals; and
- Supervise and educate other personnel involved in the individual's care.
- Ensure that required documentation is in the individual's agency record;
- Ensure that all employees are aware of the requirements to report suspected abuse, neglect, or exploitation immediately to Adult Protective Services or Child Protective Services, as appropriate-A civil penalty may be imposed on mandated reporters who do not report suspected abuse, neglect or exploitation to VDSS as required;
- Ensure services are provided in a manner that is in the best interest of the individual and does not endanger the individual's health, safety, or welfare;
- Recommend staff changes when needed;
- Report to DMAS or its contractor any unethical or incompetent practices that jeopardize public safety or cause a risk of harm to individuals, including household issues that may jeopardize the safety of the PDN; and

- Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is Medicaid fraud.

Private Duty Nursing Assessment

Upon receipt of a referral and prior to the delivery of EPSDT PDN services, the registered nurse supervisor from the provider agency must make an evaluation visit to the individual's home to conduct an assessment and introduce the nurse(s) to the individual and parent/caregiver and orient the nurse(s) to the needs of the individual.

The nursing supervisor should discuss the individual's goals, needs and physician's orders to develop the POC on the CMS-485 with the individual, family/caregiver and the private duty nurse(s) to ensure that there is complete understanding of the individual's goals and services to be provided. A copy of the current POC must be kept in the individual's home at all times. The nurse(s) should be instructed to use the POC as a guide for daily service provision. The most current POC must accompany the individual and nurse to school and whenever they leave the primary residence.

The PDN provider may not bill DMAS until the MD has signed and dated the POC. A signed copy of the current POC must be kept in the individual's home record.

It is the provider's responsibility to determine whether the agency can adequately provide services to an individual prior to accepting a referral. If, during the initial assessment, the RN supervisor determines the individual is not appropriate for PDN services because of health, safety, or welfare reasons or because the provider is unable to staff the case, the agency should not open the case to PDN. The provider RN should notify the referral source (case manager or primary care provider) that PDN services will not be provided by the agency and the reason why.

Monthly RN Supervisory Visits are performed at least every 30 days to provide oversight for all EPSDT PDN services in the home. These visits are the provider's responsibility and will include:

- An assessment of the individual based on their skilled needs

- Review of the home medical record
- A determination that health care needs are met in the home
- Documentation of the individual's satisfaction and choice of services
- Documentation of satisfaction of the service plan meeting their personal goals
- A review of the POC to ensure physician orders are accurate, current and being followed

The individual receiving EPSDT services must be present during every supervisor monthly visit.

Private Duty Nursing

Private Duty Nursing can be provided as either individual nursing or congregate nursing. Congregate Private Duty Nursing must be provided when more than one individual who receives Private Duty Nursing resides in the same home. Congregate Private Duty Nursing shall be limited to a maximum ratio of one private duty nurse to two individuals who receive nursing. The hours for each child are approved separately and a congregate rate is assigned to the hours of services that are provided to both children based on each child's medical necessity. When three or more individuals receiving Private Duty Nursing share a home, service staff ratios are determined by assessing the combined needs of the individuals. Individuals who receive congregate nursing hours may also require additional individual Private Duty Nursing hours, if medically necessary. The additional Private Duty Nursing hours may be allowed to manage higher intensity care needs or hours may be allowed to provide nursing services while the other congregate member is not present in the home.

School Based Nursing

School based nursing services are not covered by DMAS-contracted Medallion 4.0 MCOs. School based nursing services are covered by CCC Plus Managed Care MCOs. DMAS provides coverage for FFS and Medallion 4.0 enrolled members who require Private Duty Nursing in the school setting when nursing services are not being provided by the member's Local Education Agency.

Providers are responsible for determining if the individual is receiving the appropriate nursing benefit in the school system. When nursing is required during school hours, the provider must document whether nursing is included in the child's Individualized Education Program (IEP) and/or document how the school is providing or coordinating the member's nursing services. Members and their caregivers are responsible for ensuring that the student's IEP includes appropriate nursing coverage during school hours. Local School Divisions may access reimbursement using DMAS Local Education Agency/School Health Services.

Private Duty Nursing Non-Covered services:

- Care and supervision that is not medically necessary; and
- Respite.

SERVICE INITIATION AND AUTHORIZATION

All services must be service authorized. The service authorization entity varies depending on the managed care and/or waiver program in which the child is enrolled.

Program	Service Authorization Entity (Non School Hours)	Service Authorization Entity - School Hours (not covered by IEP)
FFS*	Service authorized by DMAS or its contractor.*	Service authorized by DMAS or its contractor.*
Medicaid Medallion 4.0 MCOs and FAMIS MCOs	Service authorized by MCO. Contact the MCO for service authorization information.*	Service authorized by DMAS or its contractor.*
CCC Plus Managed Care *	Service authorized by MCO, contact the MCO for service authorization information.*	Service authorized by MCO, contact the MCO for service authorization information.*
CL and FIS Waivers	Service authorized by DBHDS	Service authorized by DBHDS

*with the exception of those children enrolled in CL and FIS Waivers effective 8/1/17

PDN services are authorized based on the DMAS-62 form, Home Health Certification, Plan of Care (CMS-485) and any required documentation as detailed in the most current instructions for the DMAS-62. The individual/family or case manager acting on their behalf may request that a Physician, Physician Assistant, or Nurse Practitioner complete the

DMAS-62; a physician must sign and date the DMAS-62. The nursing agency must send required documentation to DMAS or its contractor for final approval and authorization of Private Duty Nursing hours. DMAS or its contractor will review the DMAS-62 and the POC to assess the level of need and determine if the requested service amount meets DMAS criteria for reimbursement. Private Duty Nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC signed by the child's physician and limited to the number of hours approved by DMAS or its contractor. Please see Appendix A to this Supplement for additional service authorization information.

Nursing needs of the individual documented in the DMAS-62 indicate the type and complexity of care required by assigning nursing need scores based on the time required to perform tasks corresponding to needs. The total amount of approved nursing hours may include both nursing and personal care time if the personal care tasks are incidental to the nursing care. The need for nursing care defines the amount of nursing services that are approved. The total score for the nursing needs section must be approved by DMAS or its contractor and will determine the medical necessity for nursing care.

The determination of Private Duty Nursing care hours is defined as:

Score	Nursing Hours
1 to 6 points	Individual Consideration; Consider Home Health, Skilled Nursing (if ID/DD), Personal Care Services and/or adaptive technologies
7 to 22 points	Up to 8 hours/day
23 to 36 points	Up to 12 hours/day
37 to 49 points	Up to 16 hours/day
>49 points	Individual Consideration

Dates of service for the authorization for Private Duty Nursing services cannot be before or beyond the dates of service noted on the POC. Initial requests can be submitted for up to

60 days and subsequent requests can be submitted for up to 6 months as long as the physician signs the plan to authorize that the services are medically necessary for the length of time requested. Subsequent requests for services must be authorized by DMAS or its contractor.

Hospital discharge situations may require the provision of related services such as family training provided by a nurse. The trach/vent infants going home from the NICU/PICU setting may require a higher level of nursing services to assist with the transition home. This must be documented in the 485, DMAS-62 and the nursing POC and approved by DMAS or its contractor. Nursing may be available for up to 24 hours per day during this initial period if the individual's medical necessity warrants such intensive nursing care and the care can be safely provided in the home environment.

Individuals who receive Private Duty Nursing services must receive a re-assessment by a physician every 6 months. A copy of the updated DMAS-62 must be submitted with the service authorization request. .

Private Duty Nursing will not duplicate Home Health Nursing services. If Home Health Nursing services are denied or terminated, then an individual under the age of 21 may request PDN.

MCO Service Requests

MCO members must request Private Duty Nursing through their respective MCO.

Medallion 4.0 MCO Addresses and Telephone Numbers can be found on the DMAS website at

www.virginiamanagedcare.com or by calling the Medicaid Managed Care Help Line at 1-800-643-2273. Contact information for CCC Plus Managed Care MCOs is located at http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

SERVICE AUTHORIZATION REQUIREMENTS FOR FEE-FOR-SERVICE MEMBERS

Please refer to the EPSDT Manual, Service Authorization Appendix A, for further information regarding service authorization requirements, timely submittal of requests and service specific details.

Accurate and complete authorization requests help reduce delays in authorization and service initiation. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided. The provider must have a member identification number for any authorized individual prior to requesting services.

Discharges, Transfers and Provider Notification Requirements

Providers must notify the family in writing five days prior to service termination or suspension when the discharge is not due to the health safety and welfare of the provider. The provider must notify DMAS or its contractor of all service discharges or transfers within three days of the last date of service.

The Private Duty Nursing agency must transfer a member's care to another nursing agency whenever the agency is no longer able to sufficiently staff the individual's care or the individual requests services from another agency.

For service transfers both the old provider and the new provider must exchange the individual's information prior to the new service provider beginning services.

Individuals Using Two Providers

DMAS allows more than one provider to provide Private Duty Nursing to a single

individual. Each agency must coordinate their services to ensure that the individual's service needs are met. Each agency must provide a distinct POC which includes a detailed schedule of the nursing services they provide. Both providers must perform monthly supervisory visits and send all verbal orders to the co-sharing agency. Weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues. In the event one agency releases a portion of or all approved hours to a different agency, the Medicaid LTSS Communication form (DMAS-225) must be completed by the releasing agency specifying the other PDN agency as well as the number of hours. The receiving agency must include this form when submitting their authorization request.

To inquire about the status of completed service authorization decisions:

MediCall

You may check the MediCall Automated Voice Response System 24- hours-per-day, seven days a week, to confirm recipient eligibility status, claim status and check status. The numbers are:

9996. Toll-free throughout the US

9730. Toll-free throughout the US

(804) 965-9732

Richmond and Surrounding Counties

(804) 965-9733

Richmond and Surrounding Counties

Providers access the system using their National Provider Identifier (NPI) number as identification.

Automated Response System (ARS)

Providers may use the Internet to verify recipient eligibility and perform other inquiry functions. You may contact the Conduent Web Support Call Center at 1-800-241-8726 if you have any questions or problems regarding the ARS Web Site.

DOCUMENTATION REQUIREMENTS

Services not specifically documented in the individual's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS.

The medical record must contain sufficient information to clearly identify the individual, to justify the diagnosis and treatment, and to document the results accurately.

All record documentation must be signed with the employee initials, last name, and title and be dated with complete dates (month, day, and year). A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber-stamps initialed by the physician. The physician must initial and completely date all rubber-stamped signatures.

The physician's orders may be documented on the CMS-485 form or an equivalent form which must include the following:

- Individual's ID number
- National Provider Identifier (NPI)
- Individual name and address
- Diagnosis and prognosis
- Functional limitations
- Activities permitted
- Mental status
- Safety measures
 - Orders for medications/treatments
 - Orders for dietary/nutritional needs
 - Orders for therapeutic services
 - Orders for skilled nursing services that include a specific number of nursing hours per day (i.e., not a range of hours)

- Orders for medical tests
- Measurable goals for treatment with established time frames
- Frequency/duration of services
- Rehabilitation potential
- Instructions for discharge or referral
- Discharge Status and family notification of discharge

NOTE: When designing nursing plans, please note whether a service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a licensed nurse. Nurse delegation practices as defined in the Nurse Practice Act may be used to augment the care for individuals as medically appropriate and available.

Nursing documentation for each individual must be kept at the nursing agency. The individual's nursing record must include the following:

- All plans of care (CMS-485) which must be **signed** and **dated** by the provider and the physician (per Virginia Code § 54.1-2957 and § 54.1-2957.02, signature by a Nurse Practitioner is acceptable in certain circumstances);
- CMS-485 or other form documenting the nursing POC;
- DMAS-62 **signed** and **dated** by the physician (per Virginia Code § 54.1-2957 and § 54.1-2957.02, signature by a Nurse Practitioner is acceptable in certain circumstances);
- Any required documentation for service authorization as detailed in the most current instructions for the DMAS-62;
- Any correspondence with the member's MCO to include the clinical documentation in relation to the PDN request, i.e., the plan of treatment, medical nursing needs assessment, service authorization etc;
- Social history including the family/caregivers that are trained and willing to care for the child with the supplement of nursing services and other health professionals;
- The family's support system in a schedule format;
- Any transportation requirements and how they are being met;
- Availability of the nurse including a schedule of daily nursing hours;
- Teaching efforts including delegation, assignment of care and demonstrations from caregivers regarding competency with procedural practices;
- Notes documenting each nursing visit; and
- Equipment and supplies necessary for the individual's care.

Nursing notes must include all of the following:

- All plans of care and Medical Needs Assessment Forms (DMAS-62) **signed** and **dated** by the provider and the physician (per Virginia Code § 54.1-2957 and § 54.1-2957.02, signature by a Nurse Practitioner is acceptable in certain circumstances);
- First and last name of individual on each page of documentation;
- Date of each visit;
- Time at start and end of service delivery by each nurse;
- Comprehensive assessment including medical status, functional status, emotional/mental status, nutritional status, any special nursing procedures, and identification/resolution of acute episodes;
- Treatment and/or caregiver instruction provided including the caregiver receptiveness to instruction;
- Outcomes including the individual/family's response to services delivered and response to training;
- Demonstrations of caregiver competencies in nurse-delegated tasks;
- Nursing assessment of the individual's status and any changes in status per each working shift; and
- Full signature and title of nursing provider. All signatures must include dates.

Documentation by the RN Supervisor to Support the Monthly Supervision Visit:

The RN Supervisor makes monthly home visits to assess the quality and provision of Private Duty Nursing services. This includes review of the following:

- Consistency and Continuity of Care: The degree to which the individual receives services from nursing staff familiar with the individual's needs, home environment, and POC and receives services continuously according to the POC;
- Adherence to the POC: It is the provider's responsibility to provide the necessary amount and type of services, as reflected in a current POC. A POC that calls for services to be rendered on a seven-day-a-week basis must be staffed on that basis unless the provider has discussed with the individual and social support the provider's inability to render care, and the individual's social support must be able to provide the coverage in the absence of the usual agency staff. This must be documented in the individual's file. Holidays are not exempt from the criteria;

- Documentation of Ancillary Services: The degree to which the individual receives services other than nursing;
- Identification of all other services that are needed for the individual to be maintained in the home. The documentation shall include, as appropriate, speech therapy, occupational therapy, physical therapy, transportation, physician services, the frequency and amount of service needed, the provider of the service, and the payment source;
- Contacts for the equipment supplier and respiratory therapist;
- Documentation of services (as needed and appropriate) including, but not limited to, the school system; Special Supplemental Nutrition Program for Woman, Infants, and children (WIC); child development clinic services; and other Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) services;
- Identification of the primary care physician who has agreed to manage the medical care of the individual;
- Documentation of hospitalizations and medical procedures, both inpatient and outpatient;
- Current Physician Orders for Medical Care: Physician orders must be signed and dated;
- Progress Notes: The degree to which nursing documentation reflects the individual's status, the technology required, and the skilled nursing care provided;
- Quality of Care: As reported by the individual or family or observed by the analyst during home visits;
- Health and Safety Needs of the Individual: Has the provider identified any special needs of the individual and acted to refer the individual to service providers to meet those needs?

Documentation for re-certification of services:

- All plans of care and medical needs assessment documents must be **signed** and **dated** by the provider and the physician
- Home Health Certification and Plan of Care (may use the CMS-485 or equivalent to meet documentation requirements) signed and dated by the ordering physician who is most familiar with the care needs of the individual

- The Home Health Certification and Plan of Care must contain the individual ID number, provider number, and documentation which reflects the nursing care as described in the Medical Needs Assessment (DMAS-62) form
- Medical Needs Assessment Form (DMAS-62) signed and dated by physician (required every six months)
- Any documentation required for recertification as detailed in the most current instructions for the DMAS-62.

CLAIMS AND BILLING

The unit of service for Private Duty Nursing is one hour. Payment is available only for allowable activities that are pre-authorized and provided by a qualified provider in accordance with an approved POC that meets Private Duty Nursing program criteria. Private Duty Nursing services are limited to the hours of skilled medical care and skilled supervision as specified in the POC and limited to the number of hours authorized by DMAS.

All Private Duty Nursing services are service authorized by DMAS or its contractor. Payment for Private Duty Nursing services requires an existing service authorization.

Private Duty Nursing Reimbursement Table

SERVICE NAME	REIMBURSEMENT CODE
Private Duty RN	S9123
Private Duty LPN	S9124
Private Duty Congregate Nursing RN	G0493
Private Duty Congregate Nursing LPN	G0494

EPSDT Appendix A

INTRODUCTION

Service authorization, formerly known as prior authorization, is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some may begin prior to requesting authorization.

PURPOSE OF SERVICE AUTHORIZATION

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued enrollment as a DMAS provider, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

GENERAL INFORMATION REGARDING SERVICE AUTHORIZATION

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

The service authorization entity will approve, pend, reject, or deny all completed service authorization requests. Requests that are denied for not meeting medical necessity criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request.

Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization for covered days prior to billing DMAS for these services. Providers must request a service authorization for retrospective review within 30 days from the date they are aware of the member's Medicaid eligibility determination.

MEDICAID MANAGED CARE

Children enrolled in Commonwealth Coordinated Care Plus (CCC Plus)

CCC Plus is a statewide Medicaid managed care program that serves individuals with complex care needs, including children enrolled in Home and Community Based Waivers, through an integrated delivery model that includes medical services, behavioral health services and long-term services and supports. Children enrolled in CCC Plus, with the exception of those children enrolled in the CL and FIS Waivers, may receive EPSDT Personal Care Services through the MCO. Providers and families should contact the MCO for information on obtaining service authorization for EPSDT Personal Care. Contact information for CCC Plus MCOs is located at <https://cccplusva.com/home>

Children enrolled in Medallion 4.0

MEDALLION 4.0 provides the delivery of acute and primary care services, prescription drug coverage, and behavioral health services (as specified) for eligible Medicaid, Medicaid Expansion, and FAMIS members. Detailed information on the Medallion 4.0 Program can be found on the Medallion 4.0 Program webpage at <http://www.dmas.virginia.gov/#/med4>. Contact information for Medallion 4.0 MCOs is located at <https://www.viriniamanagedcare.com/>

MEMBERS TRANSITIONING INTO MANAGED CARE

For members that transition into managed care, the health plans will honor the Service authorization service authorization contractor's authorization for a period of not less than 30 days or until the Service authorization ends whichever is sooner, for providers that are in- and out of network.

When a member enrolls in one of the managed care plans, the provider should contact the health plan to obtain an authorization and information regarding billing for services.

MEMBERS TRANSITIONING FROM MANAGED CARE TO MEDICAID FEE-FOR SERVICE (FFS)

Should a member transition from managed care to Medicaid FFS, the provider must submit a request to the Service authorization contractor and needs to advise the Service authorizationservices authorization Contractor that the request is for a managed care transfer within 30 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Service authorization Contractor will honor the managed care approval up to the last approved date but no more than 30 calendar days from the date of managed care disenrollment under the continuity of care provisions. For continuation of services beyond the 30 days, the Service authorization contractor will apply medical necessity/service criteria.

Should the request be submitted to the Service authorization Contractor after the continuity of care period:

- A. The dates of service within the continuity of care period will be honored for the 30-day timeframe;
- B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from managed care at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the Service authorization Contractor's service authorization but the member's managed care eligibility has been retro-voided, continuity of care days will not be approved by the managed care health plan and will not be on the transition reports since the member never went into managed care. The Service authorization contractor will re-open the original service authorization for the same provider upon provider notification.

Managed Care Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Service authorization Contractor will honor the managed care approved days/units under the continuity of care period for up to 30 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under managed care for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from managed care to FFS, and the provider requests an authorization for a service not previously authorized under managed care, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Service authorization Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

Additional information on the CCC Plus program is available on the DMAS website at <http://www.dmas.virginia.gov/#/cccplus>. Medallion 4.0 information is located at <http://www.dmas.virginia.gov/#/med4>.

CHANGES IN BENEFIT PLANS

Because the individual may transition between fee-for-service and the DMAS contracted managed care program, the service authorization entity will honor the DMAS contracted Managed Care Organization (MCO) service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor a service authorization based upon proof of authorization from the provider, DMAS, or the service authorization

contractor for services authorized while the member was eligible under fee-for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO. The MCO must initially honor the service authorizations issued by DMAS or its contractors from the date an individual enrolls in the MCO but may reevaluate the service authorization for medical necessity as specified by the managed care contract.

Service authorization decisions by DMAS or its contractor are based upon clinical review and apply only to individuals enrolled in Medicaid or FAMIS fee-for-service or services carved on dates of service requested. The service authorization decision does not guarantee Medicaid or FAMIS eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for MCO enrollment. For MCO enrolled members, the provider must follow the MCO's service authorization policy and billing guidelines.

COMMUNICATION

Provider manuals are located on the DMAS portal at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>. Additional service authorization information is located on the current service authorization contractor's website, <http://dmas.kepro.com>. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The service authorization entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS web portal. Changes will be incorporated within the manual.

EPSDT SERVICES REVIEWED BY DBHDS

The following EPSDT services are reviewed by the Department of Behavioral Health and Developmental Services (DBHDS) for children enrolled in the Community Living (CL) Waiver, Family and Individual Support (FIS) Waiver and Building Independence Waiver (BI):

- EPSDT Assistive Technology
- EPSDT Private Duty Nursing
- EPSDT Personal Care

DBHDS reviews these services only for children already enrolled in the CL, FIS and BI Waivers. The CL, FIS and BI Waivers were previously known as the Intellectual Disabilities (ID) Waiver, Individual and Family Developmental Disabilities Support Waiver (DD) Waiver and the Day Support Waiver. The three waivers are referred to collectively as the DD Waivers. All requests for EPSDT Private Duty Nursing, EPSDT Personal Care and EPSDT Assistive Technology for children enrolled in the CL and FIS Waivers must be submitted to DBHDS via the Waiver Management System (WaMS) by the individual's support coordinator. All required service authorization forms and documentation for these services as outlined in the EPSDT Supplement must be submitted to DBHDS for service authorization. For additional information, contact DBHDS at 804-663-7290.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT AND CCC PLUS WAIVER FOR INDIVIDUALS UNDER THE AGE OF 21

Effective September 1, 2018, individuals under the age of 21, enrolled in the CCC Plus

Waiver, must receive personal care, private duty nursing, and assistive technology through the Early Periodic Screening and Diagnostic Treatment (EPSDT) benefit. Service authorization requests for these services are to be submitted to either the respective Managed Care Organization (MCO) for individuals enrolled in managed care or to KEPRO through the Atrezzo Connect provider portal for Fee-for-Service. The Managed care plans and KEPRO will utilize EPSDT rules and required documentation in authorizing these services.

SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

For EPSDT services, KEPRO accepts service authorization requests through direct data

entry (DDE), fax, phone and US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to <http://dmas.kepro.com>. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. All authorizations should be submitted prior to the end of the current authorization in order for submissions to be timely and to avoid any gaps in service.

PROCEDURAL CHANGE FOR THE REVIEW OF FEE-FOR-SERVICE EPSDT PERSONAL CARE SERVICE AUTHORIZATION REQUESTS

Effective September 1, 2018, service authorization requests for EPSDT Personal/Attendant Care will be accepted and reviewed by KEPRO. Providers will continue to use KEPRO's secure portal, Atrezzo for submittals. The requests will continue to be processed by KEPRO with the preexisting standard of five (5) business days.

Providers will continue to submit the DMAS-7, DMAS 7-A and the personal care questionnaire or DMAS- 99.

How to Register for Atrezzo

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to <http://dmas.kepro.com>, and click on "Register" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at <http://dmas.kepro.com>: Click on the *Training* tab,

then the *General* tab.

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KEPRO.

Submitting through Atrezzo puts the request in the reviewer queue immediately. Service authorization checklists and/or questionnaires may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers may access this information by going to <http://dmas.kepro.com>.

Already Registered with Atrezzo but Need Help Submitting Requests

It is imperative that providers currently registered use the portal for submitting all requests. For EPSDT Personal Care and Private Duty Nursing providers, this includes admissions, discharges, continuation of care, change in hours, transfers, responding to pend requests, and all other transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully registered, but needs assistance submitting requests through the portal, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance is needed by the administrator contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to have a new administrator set up.

When contacting KEPRO please leave caller's full name, area code and phone number and

the best time to be contacted.

Additional Information for Ease of Electronic Submission

In order to make this transition to electronic submission easier for the providers, KEPRO and DMAS have completed the following:

1. Attestations - All providers will attest electronically that information submitted to KEPRO is within the member's documented record. If upon audit, the required documents are not in the record, and the provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.
2. Questionnaires for EPSDT Private Duty Nursing and EPSDT Personal Care services were reconfigured by KEPRO and DMAS. The questionnaires are shorter, require less information, take less time to complete, and are more user friendly.

Faxing Requests to KEPRO

Providers must use the specific fax form required by KEPRO when requesting the services listed below. If the fax form is not accompanied by the request, KEPRO will reject the request back to the provider and the provider must resubmit the entire request with the fax form. KEPRO's website has information related to the service authorization processes for all DMAS programs they review. Fax forms for the services below, service authorization checklists, questionnaires for certain services, trainings, and much more are on KEPRO's website. Providers may access this information by going to <http://dmas.kepro.com>.

Required Forms:

- EPSDT Assistive Technology - DMAS 363
- Hearing Aids and related devices - DMAS 363

Checklists and Questionnaires

Service authorization checklists and questionnaires (specific to certain services) may be accessed on KEPRO's website to assist the provider in assuring specific information is included in the electronic request in order to make a final determination for a service. Information from the DMAS required form(s) and/or required documentation may be used to complete a checklist or questionnaire. The service authorization checklists are not mandatory in order to complete the request.

If providers who submit requests for EPSDT Assistive Technology, Hearing Aids and related devices do not wish to use the service authorization checklist for web based requests, the provider may submit the completed required DMAS form(s) and/or required documentation as an attachment to the request when it is submitted.

****Note to providers, the information submitted to KEPRO for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information to KEPRO containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

Timeliness of Submission by Providers

For Services with Timely Submittal Requirement:

Providers must submit requests to KEPRO within the required time frames for each service request. See Exhibit 2 in this Appendix for specific service submittal time frames for each service type. If a provider is late submitting the request, KEPRO will review the request and make a determination from the date it was received. The days/units that were not submitted timely will be denied and appeal rights provided. KEPRO will review completed requests within the appropriate timeframe for the specific service requested and make a final determination.

Note: Hearing aids and related devices requiring service authorization through KEPRO are the exception. Refer to the EPSDT Hearing and Audiology Manual for detail.

Processing Service Authorization Requests

KEPRO or DMAS will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KEPRO or DMAS notifies the provider. The member and provider will receive a DMAS system generated letter regarding the status of the request.

If there is insufficient information to make a final determination, the request will be pended back to the provider with a request for additional information. If the information is not received within the requested time frame, the request will automatically be sent to a physician for a final determination with all information that has been submitted. Providers and members are issued appeal rights in the system generated letter for any adverse determination. Instructions on how to file an appeal are included in the system generated letter.

The Service Authorization Contractor, KEPRO, or DMAS will apply InterQual® criteria (if applicable), DMAS Manuals, Regulations and DMAS modified criteria guidelines to the medical information provided with each service request and a service authorization number will be assigned to the request.

The medical justification provided to the Service Authorization entity must meet the InterQual® Criteria upon review, if applicable. These criteria may be obtained at www.changehealthcare.com/clinical-decision-support-solutions

SPECIFIC INFORMATION FOR OUT-OF-STATE PROVIDERS

Out-of-state providers are held to the same service authorization processing rules as in state providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request for service authorization as timeliness of the request will be considered in the review process. The request will be pended for 12 business days to allow the provider to become successfully enrolled.

If confirmation of the provider's enrollment is received within 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and the information is not received within 12 business days, the service authorization request will be rejected as the service authorization cannot be entered without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to <https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the member's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for members in a particular locality to use medical resources in another state.

The provider needs to determine item 1 through 4 at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

- Pend the request utilizing established provider pend timeframes
- Have the provider research and support one of the items above and submit back to the

Contractor their findings

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

REVIEW CRITERIA TO BE USED

EPSDT specialized services are available only for Medicaid members **under age 21**. *EPSDT specialized services are not a covered service by DMAS for members age 21 and older.*

Specialized services through the EPSDT benefit are used to correct or ameliorate physical or mental conditions identified during EPSDT screening services and the member may be referred by the EPSDT screener or Primary Care Provider (PCP) for specific services. These services must be medically necessary with appropriate documentation to support each service authorization request. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. All approvals must meet these agency criteria. All criteria, including InterQual® and/or physician review criteria are used for guidelines and reference purposes only.

EPSDT specialized services are not available under the Virginia *State Plan for Medical Assistance*. Specialized services or items should directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the individuals and environment in which they live.

Services, equipment or supplies already covered by the Virginia *State Plan for Medical Assistance* may not be requested for reimbursement under EPSDT.

InterQual®: KEPRO will apply InterQual® criteria to certain services and DMAS criteria where InterQual® does not exist.



HOW TO DETERMINE IF SERVICES NEED TO BE SERVICE AUTHORIZED

In order to determine if services need to be service authorized, providers should go to the DMAS website: <http://dmasva.dmas.virginia.gov> and click on the link for Procedure Fee Files & CPT Codes. The information provided through this link indicates if a procedure code needs prior authorization or if a procedure code is not covered by DMAS.

EXHIBITS

TABLE OF CONTENTS

PAGE

SERVICE AUTHORIZATION EPSDT SERVICES..... 1

EPSDT TIMELY SUBMISSION CHART..... 2

SERVICE AUTHORIZATION EPSDT SERVICES

Exhibit 1

Service	Children Enrolled in CCC Plus MCOs*	Children Enrolled in Medicaid/ FAMIS Plus Medallion /4.0 MCOs	Children Enrolled in Medicaid/FAMIS Plus Fee-For-Service (FFS) (Includes FAMIS FFS)	Coverage for Children Enrolled in FAMIS MCOs
Assistive Technology	Contact child's MCO for service authorization*	Contact child's MCO for service authorization*	Services authorized through KEPRO*	Not covered
Hearing Aids, Orthotics, Chiropractic services	Contact child's MCO for service authorization	Contact child's MCO for service authorization	Services authorized through KEPRO	Contact child's MCO for service authorization
Private Duty Nursing	Contact child's MCO for service authorization*	Contact child's MCO for service authorization*	Services requested through Atrezzo, authorized by DMAS*	Contact child's MCO for service authorization
School Based Private Duty Nursing Included in the child's IEP	Carved out from managed care. Services requested through Atrezzo, authorized by DMAS*	Carved out from managed care. Services requested through Atrezzo, authorized by DMAS*	Services requested through Atrezzo, authorized by DMAS*	Carved out from managed care. Services requested through Atrezzo, authorized by DMAS
School Based Private Duty Nursing NOT Included in the child's IEP	Contact child's MCO for service authorization*	Contact child's MCO for service authorization	Services requested through Atrezzo, authorized by DMAS*	Contact child's MCO for service authorization
Personal Care	Contact child's MCO for service authorization*	Contact child's MCO for service authorization*	Services requested through Atrezzo, authorized by KEPRO *	Not covered

Specialized Medical Formula	Covered by MCO. Contact child's MCO for information.	Carved out from managed care. No service authorization required.	Carved out from managed care. No service authorization required.	Carved out from managed care. No service authorization required.
Specialized Inpatient	Contact child's MCO for service authorization*	Contact child's MCO for service authorization	Services authorized through DMAS Medical Services Unit (no specialized inpatient coverage for FAMIS). Fax request to (804)452-5450.	Contact child's MCO for service authorization (coverage for acute only)
Behavioral Therapy (including ABA)	Contact child's MCO for service authorization	Contact child's MCO for service authorization Contact Magellan for Service Authorization for fee-for-service members (800)424-4046		
EPSDT Therapeutic Group Homes	Contact child's MCO for service authorization	Carved out from managed care. Contact Magellan for Service Authorization (800)424-4046		Not covered
Residential Treatment Centers	Carved out from managed care. Contact Magellan for Service Authorization (800)424-4046			Not Covered
Residential Substance Abuse Treatment	Covered through MCO, see current Addiction Recovery and Treatment Services (ARTS) Manual on DMAS website for details: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual			Not Covered

**with the exception of those children enrolled in the DD Waivers*

Contact information for Medallion 4.0 Managed Care Organizations (MCOs) can be found at www.virginiamanagedcare.com Contact information for CCC Plus MCOs is located at http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

Private duty nursing in the school is available also to MCO members. This is an MCO carved out benefit for children in Medallion if the service is included in the child's IEP. For details concerning this benefit see the EPSDT PDN Manual.

These EPSDT Services are available to members enrolled in the FAMIS MCO benefit: Private Duty Nursing, Hearing Aids, Orthotics, Chiropractic Services, and Behavioral Therapy.

These EPSDT Services are available to members enrolled in the FAMIS Fee-for-Service (FFS) benefit: Assistive Technology, Private Duty Nursing, Hearing Aids, Orthotics, Chiropractic Services, Behavioral Therapy and Personal Care.

If a child has a medical need for treatment identified during an EPSDT screening that is not

covered by the Virginia *State Plan for Medical Assistance* or another EPSDT service, a request for specialized services under EPSDT may be submitted by using the EPSDT Specialized Services Treatment Referral Information Form (DMAS-355) and documentation to describe medical necessity. This form is available on the DMAS web portal at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>. If the child is enrolled in managed care, there must be documentation that the request was sent to the MCO for EPSDT consideration but was denied due to not being a covered service.

If the requested service is available through the state plan, the individual sending the request will be referred to the correct DMAS program to obtain the services.

The EPSDT Specialized Services Treatment Referral Information Form must be completed by a physician, physician assistant or nurse practitioner based on health conditions observed during the most recent EPSDT screening. The completed form and any supporting documentation should be faxed to the DMAS at 804-452-5450 or mailed to:

EPSDT Service Authorization Coordinator

Medical Support Unit

600 E. Broad Street

Richmond VA, 23219

EPSDT TIMELY SUBMISSION CHART

Exhibit 2: Applies to service authorizations performed by KEPRO and DMAS through the Atrezzo process.

Service Type	Procedure Codes	Timely Submittal Requirements
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EPSDT PDN-0090	S9123, S9124, G0493 and G0494	Initial requests must be submitted within 10 business days of start of care. For continuation of care, the request must be submitted prior to the end date of the current authorized period.
EPSDT MCO Carve Out School Services-0098	S9123, S9124, G0493 and G0494	Initial requests must be submitted within 10 business days of start of care. For continuation of care, the request must be submitted prior to the end date of the current authorized period.
EPSDT Personal Care/Attendant Care-0091	T1019/S5126	Requests for service authorization must be submitted within 10 business days of start of care. For continuation of care, the request must be submitted prior to the end date of the current authorized period.
EPSDT Orthotics-0092	Multiple codes. See DME Manual, Appendix B.	Orthotic requests - No timeframe for service authorization request submission. (Requests may be submitted prior to or after service has been delivered.)
EPSDT Chiropractic-0092	98940, 98941, 98942, 98943	Chiropractic service authorization requests must be submitted prior to the service being delivered.
EPSDT Hearing Aids and Devices- 0092	Multiple codes. See EPSDT Hearing and Audiology Manual.	Hearing aid service authorization requests may be submitted by the provider after the hearing aid service has been delivered.
EPSDT Assistive Technology 0092	T5999	Service Authorization request must be submitted prior to the service being delivered.

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. Individuals aged 19 or 20 who are covered under Medicaid expansion are eligible for EPSDT.

EPSDT Inpatient Services

EPSDT INPATIENT SERVICES

Early Periodic Screening Diagnosis and Treatment (EPSDT) inpatient services may be provided to treat a variety of complex health, mental health and neurological conditions that are generally prohibited as a primary reason for admission in the existing Medicaid state plan services. EPSDT inpatient services may be provided in a variety of inpatient settings based on the individual's complex healthcare needs. Individuals must be medically unstable due to medical conditions that require inpatient services to manage, treat and stabilize the medical condition and facilitate a return to a lower level of care. Some examples of conditions that may benefit from EPSDT inpatient treatment are: eating disorders, complex neurological conditions, acquired brain injury and other conditions with medical instability being the prime reason for admission.

This document will clarify the process to acquire specialized inpatient treatment benefits through the EPSDT benefit. The EPSDT benefit provides inpatient services when the individual requires intensive treatment and also requires management of multiple health conditions that cannot be effectively managed in a less intensive treatment setting.

EPSDT is a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. Examination and treatment services are provided at no cost to the individual. EPSDT is available to Medicaid/FAMIS Plus members under 21 years of age and fee for service FAMIS members under the age of 19 who meet medical necessity criteria for the service. Individuals aged 19 or 20 who are covered as part of Medicaid expansion are eligible for EPSDT.

Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to a Medicaid eligible individual through EPSDT even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance may be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS, its service authorization contractor or a DMAS-contracted managed care organization (MCO) to be medically necessary. Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into

account a particular child's needs.

DEFINITIONS

Activities of Daily Living (ADLs): Activities usually performed in the course of a normal day in an individual's life; and may include eating, dressing, bathing and personal hygiene, mobility including transfer and positioning, bowel and bladder assistance.

Anticipatory Guidance: A component of an EPSDT screening. It includes discussion and counseling to provide the family with information on what to expect in the child's current and next developmental phase. It emphasizes health promotion and preventive strategies. Anticipatory guidance is given in anticipation of health problems or decisions that might occur before the next periodicity visit. Anticipatory guidance topics to be considered for each visit include: health habits, prevention of illness and injury, nutrition, oral health, sexuality, social development, family relationships, parental health, community interactions, self-responsibility and school/vocational achievement. Topics may be discussed in groups or individually. Topics selected must be based on the needs of the individual child. The exact approach, topics selected, priority, and time allotted to any one topic will depend on the child's or adolescent's needs, the provider's professional judgment, and individual circumstances. The American Academy of Pediatrics (AAP) Guidelines for Health Supervision III provides guidelines on topics to cover at each periodic screening visit.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

Diagnosis and Treatment Services: Other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The state may determine the medical necessity of the service and subject the service to service authorization for purposes of utilization review.

DMAS: The Virginia Department of Medical Assistance Services (DMAS) is the state Medicaid agency that is responsible for administering the EPSDT benefit.

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment): a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, EPSDT provides examination and treatment services at no cost to the enrollee.

EPSDT Screener: DMAS enrolled or contracted Medicaid MCO enrolled Physician, Physician's Assistant, or Nurse Practitioner.

EPSDT Screening: EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and health education, including anticipatory guidance.

FAMIS: Virginia's program that helps families provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid. In Virginia, FAMIS enrollees are not eligible for some types of EPSDT specialized services when enrolled in a managed care organization.

FAMIS Plus: FAMIS Plus is the name given to the Virginia Medicaid program.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program that uses the DMAS provider network to deliver healthcare services. "FAMIS fee for service" enrollees are eligible for

EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Home: A place of temporary or permanent residence, not including a hospital, ICF/ID nursing facility, or licensed residential care facility.

Inter-periodic Screenings: Screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule above. For example, the Primary Care Provider (PCP) may choose to screen adolescents ages 11-20 in accordance with the AAP schedule rather than biannually as required by the current DMAS periodicity schedule. Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an inter-periodic screening be performed by the PCP or other screening provider.

Medicaid: Virginia's comprehensive healthcare program that serves low income and disabled populations.

Nursing: The performance of any nursing acts in the observation, care and counsel of individuals or groups who are ill, injured or experiencing changes in normal health processes or the maintenance of health and the prevention of illness or disease. Nursing includes the supervision and teaching of those who are or will be involved in nursing care along with supervision and teaching the delegation of selected nursing tasks and procedures to appropriately trained unlicensed persons as determined by the Board of Nursing. Nursing includes the administration of medications and treatments as prescribed by any person authorized by law to prescribe such medications and treatment. Professional nursing, registered nursing and registered professional nursing require specialized education, judgment, and skill based upon knowledge and application of principles from the biological, physical, social, behavioral and nursing sciences.

SERVICE AUTHORIZATION (SA): THE PROCESS OF DETERMINING WHETHER OR NOT THE SERVICE REQUEST MEETS ALL CRITERION FOR THAT SERVICE AND GIVES AUTHORITY TO PROVIDERS TO ALLOW REIMBURSEMENT FOR SERVICES. PROVIDERS AND INDIVIDUALS ARE NOTIFIED OF EACH SA DECISION WITH A SYSTEM-GENERATED NOTICE. SA FOR SPECIALIZED INPATIENT SERVICES FOR FFS

ENROLLEES IS OBTAINED AT DMAS. SA FOR MANAGED CARE ENROLLEES MUST BE OBTAINED THROUGH THE MCO.

Respite: Respite is not an EPSDT service. It is defined as short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

State Plan for Medical Assistance: The set of benefits approved by the Commonwealth of Virginia and the Centers for Medicaid and Medicare Services.

Third Party Liability (TPL): Insurance other than Medicaid that is owned by the individual or purchased on the individual's behalf. This insurance may be liable for coverage of the requested Medicaid service. TPL must be billed for services prior to billing Medicaid.

PROVIDER PARTICIPATION REQUIREMENTS:

EPSDT Inpatient Treatment may be provided by acute care inpatient hospitals, rehabilitation hospitals, rehabilitation units of acute care hospitals and, for certain enrollees, freestanding psychiatric facilities.

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. All DMAS providers are prohibited from charging enrollees for DMAS covered services. The enrollee is not responsible for payment of medical services by any facility while under care at the enrolled provider's facility.

Freestanding Psychiatric Hospitals

Reimbursement is available for FAMIS Plus/Medicaid enrollees under the age of 21 who receive psychiatric services in a freestanding psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The facility must also meet state licensure requirements.

Inpatient Rehabilitation and General Acute Care Hospitals

FAMIS Plus/Medicaid enrollees under the age of 21 and FAMIS Fee For Service enrollees under the age of 19 may receive inpatient services approved under the EPSDT benefit in rehabilitation hospitals and in rehabilitation units of acute care hospitals.

A hospital is eligible for participation in the Virginia Medical Assistance Program if it meets one of the following criteria:

Is certified by the Virginia Department of Health (VDH) as meeting the conditions for participation under Title XVIII of Public Law 89-97

Is limited to an age group not eligible for Title XVIII benefits, but is accredited by the Joint Commission on Accreditation for Hospitals and has a Utilization Review Plan that meets the Title XVIII and Title XIX standards for utilization review.

ELIGIBILITY CRITERIA

EPSDT inpatient services are available to Medicaid/FAMIS Plus enrollees under 21 years of age and FAMIS fee for service enrollees under the age of 19. **EPSDT inpatient services are available only to individuals who meet medical necessity criteria for inpatient treatment.**

Children with third party insurance are eligible to receive services through EPSDT. However, the third party insurance benefits must be exhausted prior to billing DMAS.

Inpatient Services for Medicaid/FAMIS Plus and FAMIS enrollees in Managed Care Organizations

MCO Service Requests- Inpatient services are a covered service for Managed Care Organization (MCO) enrollees. Authorization for inpatient treatment services of MCO enrollees must be requested through the member's respective MCO by the individual's physician. The Physician must contact the MCO's medical management office to initiate the authorization process for inpatient services. As mentioned above, while inpatient services are a covered service under the MCO contracts, EPSDT medical necessity criteria does not apply to FAMIS children enrolled with the MCO. In certain unique situations a FAMIS MCO

enrollee may not be eligible for inpatient treatment even if the health condition and physical or mental status meets the criteria as stated in this manual.

SERVICE AUTHORIZATION CRITERIA FOR FEE FOR SERVICE ENROLLEES

Initial Requests

Accurate and complete authorization requests help reduce delays in authorization and service initiation. To ensure timely authorization for services, all requests for service authorization must be submitted to the EPSDT Service Authorization Coordinator 10-14 calendar days prior to initiation of EPSDT services or within 1 business day of the admission. A business day is defined as 12:00 am – 11:59 pm Monday – Friday with the exception of recognized holidays. Requests that are received within this time period may have the admission date as the begin date if all other requirements are met. For those initial requests that are received after this time period, the earliest begin date possible is the date the request is received.

The provider must have a Medicaid identification number for any authorized individual prior to requesting Medicaid-funded services. Providers should not start services before receiving an authorization from DMAS. Providers wishing to start services prior to the receipt of authorization do so with the knowledge that they are taking a risk of not receiving reimbursement for services provided.

Each service approval notice will indicate the last date of service coverage. The approval notification includes the start date and the end date for each approved service. Services that are not authorized are not subject to reimbursement by DMAS.

Extension Requests

If services are needed beyond the initial authorization time frame, the provider must submit an extension request. It is recommended that extension request be submitted at least 10 days prior to the end of the initial authorization period in order to avoid a break in coverage. For those extension requests that are received after the end of the previous authorization, the earliest begin date possible is the date the request is received. For example, if a service authorization approval ends on 12/1, the provider must submit a request at least 10 days before this date in order to ensure continuation of reimbursement for services. If the request for extension is received on 12/5, the earliest date DMAS can approve the extension request will be 12/5. Therefore, the provider will not be reimbursed

for services from 12/2-12/4.

Submission of Requests

Initial Service Requests must contain the following:

1. Demographics and Service Information

1. Dates of Service being requested
2. Medicaid Identification Number and
3. Date of Birth

2. Intake and Clinical Assessment Summary

1. Briefly list and describe the recommended treatment modalities for the individual
2. Must include the reasons the individual needs interdisciplinary treatment
3. Must include the reasons the individual's treatment cannot be managed in a lower level of care
4. Case history including reasons for the referral and summary of recent treatment history
5. Preliminary discharge plan and anticipated date of discharge to a lower level of care

3. Preliminary Treatment Plan

1. List the preliminary treatment modalities prescribed for the individual
2. List the professional disciplines that will be providing treatment and acting as clinical director for the treatment modalities within the interdisciplinary team
3. Describe how treatment is coordinated and implemented for the individual
4. Describe how the individual will be trained to function independently
5. Verify that the individual can participate in the treatment milieu as defined in the treatment plan
6. Preliminary plans for discharge to a lower level of care

4. Letter of Medical Necessity

1. Physician or psychiatrist summaries that describe the current clinical event and generally describe the clinical need
2. Include diagnoses and relevant medical information to support treatment in an inpatient level of care

Extension Service Requests must contain the following:

1. Master Treatment Plan
 1. List the treatment modalities prescribed for the individual
2. Physician treatment summary
 1. Notes should describe how the current treatment protocol is impacting the child's clinical progress
 2. Describe the medication management and resulting medication changes
- c.) Must include the reasons the individual needs interdisciplinary treatment
- d.) Must include the reasons the individual's continued treatment cannot be managed in a lower level of care
- 3) Demographics and Service Information
 1. Dates of Service being requested (dates of service must match service plan with each request)
 2. Medicaid Identification Number and
 3. Date of Birth
 4. Dates of Service being requested (treatment plan must correspond with requested)
- 4) Discharge Summary
 - a.) Preliminary plans for discharge to a lower level of care
 - b.) Anticipated discharge date and disposition
 - c.) Summary of community based case management activity and status of all referrals completed for the individual to successfully return to a lower level of care

If DMAS requires more information in order to render a decision, the decision is pended. For all pended decisions, the requesting provider receives a request for the needed information from DMAS. The provider must respond with the requested information within 5 working days from the request. If DMAS does not receive enough information to make a clinical decision the request will be rejected or in some instances the request will be denied.

Denials of Service

If the service request is denied, a letter will be sent to the provider and individual/family indicating the reason for the denial. This letter will include appeal rights. Each service denial is reviewed and denied by a physician using EPSDT “correct or ameliorate” medical necessity criteria.

DMAS will provide a ten day notice before service reimbursement is ended. DMAS provides the 10 day advance notice of adverse actions by issuing a service authorization notification including the covered dates of service for each service approval. For individuals who have existing/active service authorizations and who request an extension of those services, the end date as listed on the existing/active service authorization will provide the advance notice for potential service denials if the extension request is not approved by DMAS. It is very important that providers request service authorizations in a timely manner so that reimbursement is not lost for those patients who are residing in your facility at the time when future services are denied. Active discharge planning should be an ongoing activity when individuals may not meet the medical necessity requirements for continued inpatient care.

COVERED SERVICES AND LIMITATIONS

Covered Services

EPSDT Inpatient Services consist of interdisciplinary treatment, service coordination, discharge planning and case management, nursing, behavioral support counselors, and equipment necessary to implement the treatment program

Out of State Placements

DMAS may negotiate individual contracts with in-state or out-of-state facilities for individuals who present with unique or intensive treatment needs that cannot be served within the existing DMAS provider network. Treatment options explored in-state must be documented and the reason the option was denied or would not meet the individual’s treatment needs must be included. This information must be submitted to DMAS for out of state placements to be considered.

Behavioral Support Services

The support provided by a one to one behavioral support staff may be reimbursed when authorized as part of the treatment plan and when determined to be medically necessary for the individual to participate in and benefit from the approved treatment program.

Leave of Absence

The day on which the individual begins a leave of absence or furlough is treated as a day of discharge and is not considered a day of inpatient care. The day the individual returns from a leave of absence or furlough is treated as a day of admission and is considered a day of inpatient care if the patient returns to the hospital by midnight.

It should be noted that leaves of absence are permitted for therapeutic purposes only. The objectives of the leave of absence must be documented prior to the leave, and the goals obtained and an evaluation of the leave must be documented upon the patient's return. Leaves of absence for procedures which are not available at the treating facility (for example, CAT scan, or renal dialysis) are considered medical therapeutic leaves.

Non-Covered Services

Reimbursement for services when the individual no longer meets medical necessity criteria is not covered. Special services which are not authorized by DMAS or the MCO are not covered.

Included Per Diem Services:

The following services are included as part of the per diem reimbursement.

- Interdisciplinary treatment programming
- Nursing
- Behavioral support staff using the established staff to patient ratio
- Equipment necessary to implement the treatment program

- Clinical Supervision related to the treatment plan
- Case Management/Discharge Planning
- Treatment Team Activity
- Pharmacy

Not Included in Per Diem:

The following services are not included as part of the per diem reimbursement. All services included in this list may be reimbursed separately through the Virginia Medical Assistance Program when provided by a DMAS enrolled provider. If the facility meets DMAS enrollment criteria to provide some or all of the excluded services, then they may enroll with DMAS as a provider of that service type. Service limits may apply and authorization for certain services is required.

- Any general medical needs not addressed in the inclusive per diem services listed
- Durable medical equipment or non-routine medical supplies
- Professional services and diagnostic testing outside of the treatment facility

*The facility agrees to use providers of services that are enrolled in the Virginia Medicaid program for all services not provided by the facility. The enrollee is not responsible for payment of medical services by ***any*** facility while under care at your facility.

FREESTANDING (PSYCHIATRIC) HOSPITAL UNDER AGE 21

EPSDT Inpatient reimbursement is available for FAMIS Plus/Medicaid enrollees under the age of 21 in a freestanding psychiatric hospital and other settings as appropriate to treat the primary health condition of the individual. The need for these services must have been identified through an EPSDT screening. When services are requested in a freestanding psychiatric hospital, the request must contain an independent team certification in the enrollee's locality.

The criteria for Medicaid reimbursement for inpatient psychiatric services is based on the federal regulations in 42 CFR § 441, Subpart D, and §§ 16.1-335. Any Medicaid-eligible individual seeking admission to a freestanding psychiatric hospital must be certified as

requiring inpatient services in order for the psychiatric facility to receive Medicaid reimbursement for the admission.

Independent Team Certification

Federal regulations (42 CFR § 441.152) require certification by an independent team that inpatient psychiatric services are needed for any member applying for Medicaid-reimbursed admission to a freestanding inpatient psychiatric facility. The certification must be current, within 30 days prior to placement. The independent team must include mental health professionals, including a physician. The independent team will be from the Community Services Board (CSB) serving the area in which the individual resides. Pre-screenings are not reimbursable by Medicaid. For Comprehensive Services Act (CSA) children, the independent team will be the local Family Assessment and Planning Team (FAPT) or a collaborative, multidisciplinary team approved by the State Executive Council. The majority of the team (at least 3 members) and the physician must sign the Certificate of Need/DMAS 370 form (see the “Exhibits” section at the end of this chapter for a sample of this form). Team members must have competence in the diagnosis and treatment of mental illness (preferably in child psychiatry) and have knowledge of the individual’s situation (42 CFR § 441.153). The justification for certification must be child-specific. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual’s needs or why community resources will not meet the individual’s current treatment needs.

A Medicaid-reimbursed admission to an acute care facility or a freestanding psychiatric facility can only occur if the independent team can certify that:

1. Ambulatory care resources (all available modalities of treatment less restrictive than inpatient treatment) available in the community do not meet the treatment needs of the member;
2. Proper treatment of the member’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the member’s condition or prevent further regression so that the services will no longer be needed.

The certification of need for hospital admission and for non-CSA residential placements must be documented on the Pre-Admission Screening Report (DMH 224) or similar form, which must be signed and dated by the screener and the physician. For non-CSA residential

placements the DMAS 370 may also be used. The team must indicate what less restrictive community resources have been accessed and failed to meet the individual's needs or why community resources will not meet the individual's current treatment needs.

If a child resided in a psychiatric residential facility, requires an acute psychiatric admission, and is returning to a psychiatric residential facility, a new Certificate of Need is required. The certification may be completed by the acute facility physician and treatment team as long as the physician meets the criteria noted in federal regulations 42 CFR 441.152-153.

A physician, physician assistant, or nurse practitioner acting within the scope of practice and under the supervision of a physician must recertify for each member that inpatient psychiatric services are needed. This must be done at least every 60 days.

MEDICAL NECESSITY CRITERIA

1. The individual must require all of the following services:
 - Physician assessment and clinical direction
 - Psychiatric or Neuropsychiatric assessment and clinical direction
 - Psychotherapy including family psychotherapy
 - Behavioral Modification including training in adaptive functioning (must include family and caregiver training once discharge dates are established)
 - Active Medication Management
2. The individual must also require two (2) or more of the following services based on their clinical needs
 - Psychiatric Nursing or Rehabilitative Nursing
 - Physical Therapy
 - Occupational Therapy
 - Speech/Language Pathology Services;
 - Nutritional Services
3. Treatment Plan goals should address how the individual will increase adaptive and functional behaviors based on the individual's cognitive abilities.
4. Treatment Plan goals should be realistic and possible to achieve within the approved period of admission.

5. Individual must require coordinated interdisciplinary treatment based on the complexity and intensity of the person's medical conditions.
6. An intensive coordinated interdisciplinary team approach is not available at a lower level of care.
7. The individual is able to actively participate and benefit from the treatment regimen as listed in the service plan
8. The Treatment Plan must describe how the individual's ability to function as independently as possible will be addressed.
9. Description of the discharge plan and goals towards reaching the intended plan.
10. Documentation that supports all of the above requirements must be submitted with the service authorization request.

Continuing Stay Criteria:

If the initial authorized treatment time period is not sufficient to achieve the individual's goals and discharge is not possible, the provider must request additional days of treatment. Below is non-inclusive list of items that must be submitted to DMAS for consideration of an extended authorization.

1. A clear medical justification of why all admission goals were not achieved within the initial period of authorization.
2. Documentation that demonstrates significant improvement of the patient's medical conditions and the justification for continued stay must demonstrate how treatment is expected to increase adaptive and functional behaviors.
3. Increased functioning must be demonstrated by baseline comparisons as developed during the initial treatment period.
4. Individual must continue to require coordinated interdisciplinary treatment based on the complexity and intensity of the person's medical conditions.
5. Demonstration that an intensive coordinated interdisciplinary team approach is still not available/appropriate at a lower level of care.
6. The individual continues to be able to actively participate and benefit from the treatment regimen as listed in the service plan.

7. The treatment plan must describe how the individual's ability to function as independently as possible will continue to be addressed.
8. Documentation that supports all of the above requirements must be submitted with the service authorization request for an extension.
9. Description of progress towards intended discharge plan.

Discharge Criteria:

EPSDT Inpatient services do not meet reimbursement criteria when the individual's clinical care needs meet one of the criteria listed below:

1. All treatment goals are met,
2. The individual does not require coordinated treatment from multiple disciplines
3. The individual would successfully benefit from a lower level of care
4. The individual does not benefit from treatment or
5. The individual refuses to participate.

INDIVIDUAL'S RIGHT TO APPEAL AND FAIR HEARING

The Code of Federal Regulations at 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the individual. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the individual will be expected to repay DMAS for all services received during the appeal period. For this reason, the individual may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not

terminate or reduce services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The individual or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street, 11th floor

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. Documents received after 5:00 p.m. on the deadline date shall be untimely.

PROVIDER APPEALS OF ADVERSE ACTIONS

State Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action, which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of

Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of denial to the Maternal and Child Health Division at the following address: NEEDS UPDATING

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, the provider may appeal the reconsideration decision.

A provider may appeal an adverse decision where a service has already been provided, by filing a written notice for a first-level appeal with the DMAS Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street, 11th Floor

Richmond, VA 23219

If the provider is dissatisfied with the first-level appeal decision, the provider may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia*, § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street, 11th Floor

Richmond, VA 23219

Administrative appeals of adverse actions concerning provider reimbursement are heard in accordance with the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) (the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

If the provider is dissatisfied with the second-level appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The normal business hours of DMAS are from 8:00 am through 5:00 pm. Documents received after 5:00 p.m. on the deadline date shall be untimely.

The provider may not bill the member (client) for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

DOCUMENTATION REQUIREMENTS

For each individual, there must be a written plan of care/treatment plan established and periodically reviewed and signed and dated by a physician. Services not specifically documented in the individual's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS or its contractors. Each entry in the medical record must be signed and dated (month/day/year) by the provider of treatment.

The medical record must include all of the following, but is not limited to:

- Diagnosis, current medical findings, including functional status, and the clinical signs and symptoms of the individual's condition, including the diagnosis justifying admission, and documentation of the extent to which the individual is aware of the diagnosis and prognosis;
- An accurate and complete chronological picture of the individual's clinical course and treatments, including any prior rehabilitation/inpatient treatment. If appropriate, the summary of treatment furnished and the results achieved during previous periods of rehabilitation services or institutionalization must be provided;
- Plans of care/treatment plans by the interdisciplinary team and each involved discipline, specifically designed for the individual to include realistic, individualized, measurable, individual-oriented goals with time frames for achievement;
- Physician orders and plan of care/treatment plan prior to the provision of services;
- Documentation of all treatment rendered to the individual with specific attention to the frequency, duration, interventions, response, and progress toward established goals. All entries must be fully signed and fully dated (include month, day and year) by the provider of the treatment (include the full name and title);
- Documentation of supervision of therapy assistants completed by a licensed therapist every 30 days;
- Documentation of changes in the individual's condition and changes in the plans of care/treatment plans (team and/or individual discipline);
- Documentation treatment team conferences and consultations, including the names of all attending;
- Discharge plans (see below); and
- Discharge summaries describing functional outcome, follow-up plans, and discharge disposition. The discharge summaries must be completed within 30 days of the individual's discharge.

Discharge Planning

Discharge planning must be an integral part of the overall plan of care/treatment plan developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The individual and/or the responsible party shall participate in the discharge planning. The discharge plan must demonstrate that adequate arrangements/services are made to meet the individual's needs in the new environment. Documentation concerning changes in the discharge plan as determined by the response to treatment, shall be entered into the record at least every two weeks as a part of the team conference, but more often if the individual's situation warrants.

Interdisciplinary Team

The interdisciplinary (ID) team must prepare written documentation of the ID plan of care/treatment plan within seven (7) calendar days of admission.

Documentation must include, but is not limited to:

- Needs of the individual;
- Individualized, measurable individual oriented long and short-term goals;
- Approaches/interventions to be used to meet the goals;
- Baseline data on goal performance
- The discipline(s) responsible for the interdisciplinary goals;
- Evidence of goal revision and progress;
- Time frames for all goals ; and–
- Team plan reviewed/revised at least every two (2) weeks

Included in the interdisciplinary plan of care/treatment plan must be a discharge plan. This plan must facilitate an appropriate discharge and must include, but is not limited to:

- Anticipated improvements in functional levels;
- Time frames necessary to meet the goals;
- Individual's discharge destination;
- Any modifications and alterations necessary at the individual's home for discharge; and
- Alternative discharge plans if the initial plan is not feasible.

Since the effectiveness of an interdisciplinary treatment program depends on the continuing coordination of all the disciplines involved in the individual's treatment, team conferences must be held at least every two weeks in order to review the plan of care/treatment plan, assess and document the individual's progress as well as any problems impeding progress. The team will consider possible resolutions to the identified problems, reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation, reassess the need for any adjustment in these goals or in the prescribed treatment program, and re-evaluate discharge plans. Documentation must demonstrate a coordinated team approach. A review by the various team members of each others' progress notes does not constitute a team conference. A summary of the conference, noting the team members present, must be recorded in the clinical record at least every two weeks. Team conferences (identifying those persons attending the meeting), must be held at least every two weeks to review the plan of care/treatment plan. Documentation must include approaches and progress made toward meeting established interdisciplinary goals, revisions/changes to goals, and the discharge plan.

CLAIMS AND BILLING

For detailed reimbursement instructions please refer to the billing instructions located in Chapter 5 of the DMAS Hospitals Manual.

All services require authorization by DMAS. The revenue code used is an all inclusive revenue code to be reimbursed on a "per diem" basis.

UB-04 Billing Codes used for EPSDT inpatient services:

0770 Preventive Treatments

On the CMS-1450 (UB-04) form:

- Locator 63: Treatment Authorization Code - Enter the 11-digit preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.

Send claims for approved enrollees to:

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Maintain the providers copy in your files for future reference.

EPSDT Audiology and Hearing

PURPOSE

This document will clarify the process to acquire hearing aids and audiology services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. EPSDT services are available to Medicaid/FAMIS Plus members under 21 years of age and fee for service (FFS) FAMIS members under the age of 19. Individuals aged 19 or 20 who are covered under Medicaid expansion are eligible for EPSDT. Managed Care enrolled FAMIS children are not eligible for the full scope of EPSDT services; however the managed care organizations (MCO) cover Audiological and Hearing Services for FAMIS enrolled children. The contact information for MCOs can be found at www.virginiamanagedcare.com Hearing and Audiology services are available to eligible children who have demonstrated a medical need for hearing devices and ongoing Audiology services.

BACKGROUND/DISCUSSION

EPSDT is a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. Examination and treatment services are provided at no cost to the individual.

Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to a Medicaid eligible individual through EPSDT even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population. Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance may be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS, its service authorization contractor or a DMAS-contracted managed care organization (MCO) to be medically necessary. Determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account a particular child's needs.

DEFINITIONS

Analog Hearing Aids – These hearing devices use a traditional analog signal processor that allows minimal modifications by an audiologist. Analog hearing aids use older technology, and are no longer recommended for children.

Audiologist – A licensed professional who engages in the practice of audiology as defined by § 54.1-2600 of the Code of Virginia. "Audiology" means services provided by a qualified audiologist licensed by the Board of Audiology and Speech-Language Pathology and includes: the practice of conducting measurement, testing and evaluation relating to hearing and vestibular systems, including audiologic and electrophysiological measures, and conducting programs of identification, hearing conservation, habilitation, and rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems and modifying communicative disorders related to hearing loss including but not limited to vestibular evaluation, electrophysiological audiometry and cochlear implants. Any person offering services to the public under any descriptive name or title which would indicate that audiology services are being offered shall be deemed to be practicing audiology.

BICROS – "Bilateral Contralateral Routing of Signal" type hearing aid.

BTE – "Behind The Ear" hearing aid

Centers for Medicare and Medicaid Services (CMS) - The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

CIC - “Completely In the Canal” type of hearing aid.

CROS - “Contralateral Routing of Signal” type hearing aid.

Diagnostic and Treatment Services - Other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The state may determine the medical necessity of the service and subject the service to service authorization for purposes of quality management review.

DMAS - The Virginia Department of Medical Assistance Services. DMAS is the state Medicaid agency and is responsible for administering the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) -

a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children’s health care needs through periodic screenings. Examination and treatment services are provided at no cost to the individual.

EPSDT Screener - DMAS enrolled or contracted Medicaid Managed Care Organization (MCO) enrolled Physician, Physician’s Assistant, or Nurse Practitioner.

EPSDT Screening - EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests, (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and Health education, including anticipatory guidance.

ITC: In the Canal type of hearing aid.

ITE: “In The Ear” type of hearing aid.

FAMIS: FAMIS is Virginia’s State Children’s Health Insurance Program (SCHIP) program that helps families who are over the income limits for Medicaid, provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid and is covered by Title XXI of the Social Security Act. Children enrolled in FAMIS are eligible for hearing aid and audiological services that are equitable to Medicaid coverage.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two delivery programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program that uses the DMAS provider network to receive healthcare services. “FAMIS fee for service” members are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Licensed Hearing Aid Specialist: A person who engages in the practice of fitting and dealing in hearing aids or who advertises or displays a sign or represents himself as a person who practices the fitting and dealing of hearing aids. A Hearing Aid Specialist is licensed in Virginia by the Department of Professional and Occupational Regulation. Board for Hearing Aid Specialists and Opticians for the practice of fitting and dealing in hearing aids, as defined in § 54.1-1500 of the Code of Virginia.

Inter-periodic screenings: These are screenings that are provided outside of and in addition to the regular periodic screenings in the periodicity schedule above. For example, the PCP may choose to screen adolescents ages 11-20 in accordance with the AAP schedule rather than biannually as required by the current DMAS periodicity schedule. Any medical provider or a qualified health, developmental or educational professional who comes in contact with the child outside of the formal health care system may request that an inter-periodic screening be performed by the PCP or other screening provider.

Otolaryngologist: A licensed physician specializing in ear, nose and throat disorders.

Service Authorization: The process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services. Providers and individuals are notified of each service authorization decision with a system-generated notice. Service authorizations for FFS members are obtained at KePRO. Service authorizations for Managed Care members must be obtained through the MCO.

State Plan for Medical Assistance or “the Plan”: The federally approved plan outlining Virginia’s Medicaid covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

Third Party Liability (TPL): When insurance other than Medicaid owned by the individual or purchased on the individual’s behalf; may be liable for coverage of the requested Medicaid service. TPL must be billed for hearing and audiology services prior to billing Medicaid.

PROVIDER REQUIREMENTS

Audiology

Audiology services can be provided by an Otolaryngologist or a licensed Audiologist.

An Otolaryngologist must have a current license as a physician with a specialty in Ear Nose and Throat medicine. An audiologist must have a current license from the Board of Audiology and Speech-Language Pathology.

Audiology services are not reimbursable by DMAS when provided by nursing staff or a hearing aid specialist without a license in audiology.

Hearing Aids

All Hearing Aid dispensing providers must be licensed as a Hearing Aid Specialist by the Department of Professional and Occupational Regulations through the Board of Hearing Aid Specialists. Any professional who is a licensed audiologist or an otolaryngologist must have an additional license as a Hearing Aid Specialist in order to dispense hearing aids through DMAS.

Individuals who are licensed only as a Hearing Aid Specialist may enroll as a Hearing aid provider. Audiologists and other agency types may enroll separately as a hearing aid provider at their discretion in order to provide hearing aids.

If a licensed professional, a hearing aid specialist, or an agency that employs a hearing aid specialist wants to participate as an EPSDT Hearing Aid Provider, they can find the DMAS provider application on the DMAS website at www.virginiamedicaid.dmas.virginia.gov under Provider Services, then select Provider Enrollment.

Providers may also apply by contacting Provider Enrollment at:

Virginia Medicaid – PES

P.O. Box 26803

Richmond, Virginia 23261-6803

Telephone Numbers:

(804) 270-5105 local

(888) 829-5373 toll free

Fax Number: (888) 335-8476

ELIGIBILITY CRITERIA

EPSDT services are available to Medicaid/FAMIS Plus members under 21 years of age and FAMIS fee for service members under the age of 19. Individuals aged 19 or 20 who are covered as part of Medicaid expansion are eligible for EPSDT. Audiology and hearing aid services are provided to EPSDT eligible persons who have demonstrated a medical need for Audiology and Hearing Aid Services. An audiology evaluation is necessary to evaluate the need for treatment. DMAS will reimburse for audiological evaluations without service authorization.

1. The individual must be enrolled in Medicaid/FAMIS Plus or FAMIS Fee for Service;
2. Audiology services are available based on referrals from outside agencies, schools and caregivers;
3. All hearing aids require a referral from the primary care physician or otolaryngologist;
4. Hearing Services must be provided through Hearing Aid Specialists, Audiologists, and Otolaryngologists who are currently licensed as a hearing aid specialist who have current participation agreements with DMAS.

SERVICE INITIATION AND REFERRAL PROCESS

Children under 18 years of age cannot be fitted with a hearing aid(s) unless the licensed Hearing Aid Specialist has been presented with a written statement signed by a licensed physician stating the child's hearing loss has been medically evaluated and the child may be considered a candidate for a hearing aid. The medical evaluation must have taken place within the preceding six months. The DMAS-352 form must be used to document the physician authorization and this form must be retained by providers related to all claims for

new hearing aids.

All audiology and hearing aid services should be reported by the provider of services to the individual's primary physician and any other referring physicians or agencies to promote a medical home model of care and to allow the primary physician to be informed of these services as they may apply to all treatment services for the individual.

Hearing Services Referral Process

1. Evaluation by an Otolaryngologist, and/or audiologist to determine whether a hearing loss exists and the cause of the loss;
2. Medical intervention for correctable hearing losses by the physician;
3. Evaluation for hearing devices by an Otolaryngologist, and/or audiologist as appropriate to the type of hearing loss;
4. Referral to Hearing Aid Specialist for device acquisition per Virginia Hearing Aid Specialist regulations;
5. Device ordering/service authorization as appropriate; and
6. Fitting and assessment of the hearing aid by an Audiologist and/or Hearing Aid Specialist;
7. Dispensation and fitting activities, instruction and follow up care of the hearing aid for the manufacturer's standard warranty period.

Audiology and Hearing Aid Services for Individuals in Managed Care Organizations

DMAS, its contracted MCOs and their providers have the responsibility to provide EPSDT diagnostic and treatment services to all Medicaid/FAMIS Plus members under age 21. The full scope of EPSDT treatment is available to all children of Medicaid/FAMIS Plus regardless of their chosen MCO. Therefore, the EPSDT benefit is consistently available to all children enrolled in Medicaid/FAMIS Plus. The EPSDT screenings, treatment, and diagnostic benefits are the same whether they are provided through the member's MCO provider network or through FFS provider network.

EPSDT audiology and hearing aid services are included in the services provided by a DMAS-contracted MCO. If an individual who is enrolled with a MCO requires audiology and hearing aid services the individual must contact the MCO medical management office to initiate audiology and hearing aid services.

Managed Care enrolled FAMIS children are not eligible for the full scope of EPSDT services; however the managed care organizations (MCO) cover Audiological and Hearing Services for FAMIS enrolled children.

The Contact information for MCOs can be found at www.viriniamanagedcare.com

SERVICE AUTHORIZATION REQUIREMENTS

Service Authorization for FFS members for hearing aid services is obtained through DMAS' Service Authorization Contractor, KePRO. DMAS requires service authorization for all hearing aids that do not have a reimbursement rate assigned (refer to the billing and exhibit section of this document) to their respective HCPCS code. If a device does not have a reimbursement rate or when the service frequency exceeds the allowed units for that device type then the device requires service authorization. Hearing Aid Assessments do not require service authorization. If the reimbursement amount is listed as \$0, then the provider can bill DMAS directly for that service. Devices that cost the provider beyond the assigned rate must be service authorized.

For example: the exceptions to this policy might be hearing devices which are required as part of a Bone Anchored Hearing (BAHA) system, hearing aids which are part of a cochlear implant, or FM Systems, or a repair cost that exceeds the allowance for V5014. Medical necessity will be reviewed for such instances to determine if the individual's hearing can be augmented appropriately with the use of lower cost items. In such cases service authorization is required and the device function must be documented using objective measurements by a professionally calibrated instrument appropriate to measure the function of the device.

Request for new hearing devices (new hearing aids) must contain the following:

1. Completed DMAS-352, signed by a physician including HCPCS codes for all related services;
2. Most recent audiological evaluation report;
3. Quote from supplier to document provider's wholesale cost or cost description for requests to exceed allowed reimbursement rates; and

4. Discuss reasons for exceptional coverage requests.

Requests for special cost consideration or repairs must contain the following:

1. Quote from supplier to document provider's wholesale cost or cost description for requests to exceed allowed reimbursement rates and
2. Discuss reasons for exceptional coverage requests

Timeliness for provider submission does not apply:

- Hearing aid requests may be submitted by the provider after the hearing aid/related devices item/service has been delivered.
- Service authorization approvals that are completed prior to the hearing aid service being rendered are approved for the dates of service requested by the provider; 1 unit and 30 days or multiple units for up to six months.
- Administrative denials would occur if the provider did not respond to a pended request for initial clinical information.

Providers must submit requests when they are aware of the need for the hearing aid/service. Providers should expect a response from KePRO within 3 business days of receipt. If the service request is approved, DMAS will provide a service authorization number to the provider for use in claims. If the request is denied, notification will be sent to the provider and the member and appeal rights will be provided.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. Prior to the end of the current service authorization period, if the member continues to need services, the provider must submit a request within 14 days of the current service authorization expiration. This action avoids any gap in service.

Refer to the EPSDT Manuals, Service Authorization Appendix A, for further information regarding service authorization, submittal of requests and service specific details.

MCO Service Requests

MCO members must request hearing aids through their respective MCO.

COVERED SERVICES AND LIMITATIONS

Audiology

Audiological evaluations are covered without service authorization using the most current standard CPT codes. The list of covered services including service frequency limits are listed in the claims and billing section of this document.

DMAS will cover the full range of evaluative services for otolaryngology and audiology functioning. Audiology services must be provided by a licensed Audiologist or Otolaryngologist. Outpatient clinic-based services may be provided under the direction of a physician and billed as an outpatient clinic service. When medically necessary, multiple assessments are allowed on the same day of service.

A qualified Audiologist may provide the following services:

- Identification of children with hearing loss;
- Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the rehabilitation of hearing;
- Referral for genetic counseling;
- Rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems;
- Provision of treatment and therapeutic activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing evaluation, and speech conservation, treatment related to cochlear implants;
- Creation and administration of programs for prevention of hearing loss;
- Guidance of children, parents, and teachers regarding hearing loss; and
- Determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, evaluating the effectiveness of amplification.

Hearing Aids and Related Devices

Hearing aids are a benefit available exclusively to individuals under the age of 21. All

hearing aids without assigned rates as listed in this document and assistive devices such as FM systems require service authorization. Hearing aid dispensation, fitting fees, device related repairs and supplies do not require service authorization.

Hearing aid dispensing is allowed once each time a new hearing device is authorized and also when a hearing aid is replaced by the dispenser through a manufacturer's loss and damage policy.

A new hearing aid is allowed every 5 years. If a member requires a new device within 5 years then service authorization is required. Service authorization decisions are based on McKesson InterQual® criteria to determine medical necessity.

Modifications to Criteria:

- Adult >17 years change to Adult 21 years of age and older
- Pediatric ≤ 17 years change to Pediatric under 21 years
- Any modifications made to McKesson InterQual® by DMAS Medical Director

Ear molds (V5264) and supplies (V5267) such as cleaning kits for the hearing aid are allowed with each new hearing aid. Ear molds and supplies are billed using separate codes from the main hearing aid code and do not require service authorization. Ear molds (V5264) can be made and billed as often as warranted due to child's growth and acoustic needs. Supplies (V5267) can be billed twice (2) per year under the service limit. Refer to the "Exhibits" section in this manual for tables listing DMAS approved codes, service limits, rates and codes requiring service authorization by KePRO.

Warranties, Repairs and Supplies

1. New hearing aids must carry the manufacturer's standard defect warranty and the loss and damage warranty.
2. DMAS will reimburse for repairs and an extended warranty fee using the hearing aid repair HCPCS code V5014. When a repair costs more than the DMAS allowed charge per unit, the additional amount requires service authorization. A maximum of two repairs are allowed per year (per affected ear). Repair charges are not allowed when the manufacturer's original warranty is in effect.

3. Six batteries per ear per month are allowed. For example = 36 units for six months for one ear or 72 units for six months for two ears. Each month's allowance must be listed separately on the claim form. Providers should bill the maximum allowance of six units within the calendar month.

DOCUMENTATION REQUIREMENTS

Audiology Documentation

Documentation for audiology assessment, evaluation and treatment services must be kept in the members' record and must include the following:

1. Any assessments and/or evaluation reports including documentation of correspondence with the medical home for the member;
2. The testing methods used in the hearing aid evaluation including real ear measurements;
3. A plan of care specifically designed for the member who is receiving treatment services. Treatment notes include the anticipated level of functional improvement and documentation of functional improvements, any therapeutic interventions to be addressed by the audiologist, and identification of a discharge and/or maintenance plan; and
4. Recommendations for follow-up care must be noted in reports to physicians or others involved in the members care.

Hearing Aid Documentation

All hearing aids require a referral from the primary care physician or otolaryngologist in order to meet federal EPSDT requirements. This can be completed using the DMAS-352 Certificate of Medical Necessity (CMN). Forms are available at: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch>.

DMAS 352 Documentation Requirements:

- Demographic data including provider identification information is entered in section I;
- Member information including diagnosis codes are entered in section II;
- Device/Equipment are indicated in section III;
- Request information must include the specific HCPCS code and the quantity for the

prescribed hearing aid in section III; and

- The ordering physicians name, signature, and National Provider Identifier I.D.# are provided in section IV.

Ongoing Service Documentation:

- The date and necessity for services such as repairs, maintenance of devices and compliance with warranty requirements by the member and the supplying manufacturer;
- Reasons for fitting fee and dispensation related services;
- Reasons for new ear molds;
- Documentation of all supply ordering and delivery of each hearing device and supply provided;
- Documentation of all hearing aid checks and associated real ear measurements; and
- Documentation of all follow-up care for persons with cochlear implants.

EXHIBITS

DMAS Hearing Aid and Audiology Reimbursement Codes

Hearing Aid Codes Authorized by Service Authorization Contractor/KePRO

DMAS Hearing Aid and Audiology Reimbursement Codes

	DMAS Hearing Program Current Procedural Codes	
Proc Codes	Service Description	Service Limit
HCPCS	<i>**Devices use HCPCS system, assessment uses CPT</i>	
V5008	Hearing Screening	Use CPT
V5010	Assessment For Hearing Aid	Use CPT

V5010	Assessment For Hearing Aid	Use CPT
V5011	Fitting, Orientation/ Checking Of Hearing Aid	4 per year
V5014	Repair/Modification Of Hearing Aid	2 per year
V5020	Conformity Evaluation	N/A
V5030	Hearing Aid, Monaural, Body Worn, Air Conduction	1 per 60 mos
V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction	1 per 60 mos
V5050	Hearing Aid, Monaural, In The Ear (Ite)	1 per 60 mos
V5060	Hearing Aid, Monaural, Behind The Ear (Bte)	1 per 60 mos
V5070	Glasses, Air Conduction	1 per 60 mos
V5080	Glasses, Bone Conduction	1 per 60 mos
V5090	Dispensing Fee, Unspecified Hearing Aid	1 per 60 mos
V5095	Semi-Implantable Middle Ear Hearing	1 per 60 mos
V5100	Hearing Aid, Bilateral, Body Worn	1 per 60 mos
V5110	Dispensing Fee, Bilateral	1 per 60 mos
V5120	Binaural, Body	1 per 60 mos
V5130	Hearing Aid, Binaural, Ite	1 per 60 mos
V5140	Hearing Aid, Binaural, Bte	1 per 60 mos
V5150	Binaural, Glasses	1 per 60 mos
V5160	Dispensing Fee, Binaural	1 per 60 mos
V5170	Hearing Aid, Cros, In The Ear	1 per 60 mos
V5180	Hearing Aid, Cros, Behind The Ear	1 per 60 mos
V5200	Dispensing Fee, Cros	1 per 60 mos
V5210	Hearing Aid, Bicros, In The Ear	1 per 60 mos
V5220	Hearing Aid, Bicros, Behind The Ear	1 per 60 mos
V5241	Dispensing Fee, Monaural Hearing Aid, Any Type	1 per 60 mos
V5242	Hearing Aid, Analog, Monaural, Cic (Completely In The Ear Canal)	1 per 60 mos
V5243	Hearing Aid, Analog, Monaural, Itc (In The Canal)	1 per 60 mos
V5244	Hearing Aid / Digitally Programmable Analog / Monaural / CIC	1 per 60 mos
V5245	Hearing Aid / Digitally Programmable Analog / Monaural / ITC (Canal)	1 per 60 mos
V5246	Hearing Aid / Digitally Programmable Analog / Monaural / ITE (In-the-Ear)	1 per 60 mos
V5247	Hearing Aid / Digitally Programmable Analog / Monaural / BTE (Behind-the-Ear)	1 per 60 mos
V5248	Hearing Aid, Analog, Binaural, CIC	1 per 60 mos
V5249	Hearing Aid, Analog, Binaural, ITC	1 per 60 mos
V5250	Hearing Aid / Digitally Programmable / Analog /Binaural /CIC (Completely in Canal)	1 per 60 mos
V5251	Hearing Aid / Digitally Programmable / Analog /Binaural /ITC (Canal)	1 per 60 mos
V5252	Hearing Aid / Digitally Programmable / Analog /Binaural /ITE (In-the-Ear)	1 per 60 mos
V5253	Hearing Aid / Digitally Programmable / Analog /Binaural /BTE (Behind-the Ear)	1 per 60 mos
V5254	Hearing Aid, Digital, Monaural, CIC	1 per 60 mos
V5255	Hearing Aid, Digital, Monaural, ITC	1 per 60 mos
V5256	Hearing Aid, Digital, Monaural, ITE	1 per 60 mos
V5257	Hearing Aid, Digital Monaural BTE	1 per 60 mos
V5258	Hearing Aid, Digital, Binaural, CIC	1 per 60 mos
V5259	Hearing Aid, Digital, Binaural, ITC	1 per 60 mos
V5260	Hearing Aid, Digital, Binaural, ITE	1 per 60 mos
V5261	Hearing Aid, Digital, Binaural, BTE	1 per 60 mos
V5262	Hearing Aid / Disposable / Any Type / Monaural	1 per 60 mos
V5263	Hearing Aid / Disposable / Any Type / Binaural	1 per 60 mos
V5264	Ear Mold/ Insert, Not Disposable, Any Type	2 per 3 mos
V5266	Battery For Use In Hearing Device	6 per month
V5267	Hearing Aid Supplies	2 per year
V5273	Assistive Listening Device Cochlear Implant Type	1 per 60 mos
V5274	Assistive Listening Device (Not Otherwise Classified)	1 per 60 mos
V5275	Ear Impression, Each	not covered
V5281	Assistive Listening Device, FM system, Monaural	1 per 60 mos
V5282	Assistive Listening Device, FM system, Binaural	1 per 60 mos
V5283	Assistive Listening Device, FM /DM Neck, loop induction receiver	1 per 60 mos
V5284	Assistive Listening Device, FM /DM, ear level receiver	1 per 60 mos
V5285	Assistive Listening Device, FM /DM, direct audio input	1 per 60 mos
V5286	Assistive Listening Device, personal FM /DM blue tooth receiver	1 per 60 mos
V5287	Assistive Listening Device, personal FM /DM receiver, not otherwise classified	1 per 60 mos
V5288	Assistive Listening Device, personal FM /DM transmitter, assistive listening device	1 per 60 mos
V5289	Assistive Listening Device, Personal FM/DM Adapter/Boot coupling Device for receiver, any type	1 per 60 mos
V5290	Assistive Listening Device, Transmitter or Microphone, any type	1 per 60 mos
V5298	Hearing Aid, Not Otherwise Classifi	1 per 60 mos
V5299	Hearing Service, Miscellaneous	1 per 60 mos

HEARING ASSESSMENT AND EVALUATION CODES		
CPT PROC CODES	PROCEDURE DESCRIPTION	Service Limits
92551	Screening Test, Pure Tone, Air Only	N/A
92552	Pure Tone Audiometry (Threshold); A	N/A
92553	Pure Tone Audiometry (Threshold); A	N/A
92555	Speech Audiometry Threshold;	N/A
92556	Speech Audiometry Threshold; With S	N/A
92557	Comprehensive Audiometry Threshold	N/A
92559	Audiometric Testing Of Groups	N/A
92560	Bekeasy Audiometry; Screening	N/A
92561	Bekeasy Audiometry; Diagnostic	N/A
92562	Loudness Balance Test, Alternate Bi	N/A
92563	Tone Decay Test	N/A
92564	Short Increment Sensitivity Index (N/A
92565	Stenger Test, Pure Tone	N/A
92567	Tympanometry (Impedance Testing)	N/A
92568	Acoustic Refl Threshold Tst	N/A
92569	Acoustic Reflex Decay Test	N/A
92571	Filtered Speech Test	N/A
92572	Staggered Spondaic Word Test	N/A
92573	Lombard Test	N/A
92575	Sensorineural Acuity Level Test	N/A
92576	Synthetic Sentence Identification T	N/A
92577	Stenger Test, Speech	N/A
92579	Visual Reinforcement Audiometry (Vr	N/A
92582	Conditioning Play Audiometry	N/A
92583	Select Picture Audiometry	N/A
92584	Electrocochleography	N/A
92585	Auditory Evoked Potentials For Evok	N/A
92586	Auditory Evoked Potentials For Evok	N/A
92587	Evoked Otoacoustic Emissions; Limit	N/A
92588	Evoked Otoacoustic Emissions; Compr	N/A
92589	Central Auditory Function Test(S) (N/A
92590	Hearing Aid Examination And Selection Monaural	N/A
92591	Hearing Aid Examination And Selection Binaural	N/A
92592	Hearing Aid Check; Monaural	6 per year
92593	Hearing Aid Check; Binaural	6 per year
92594	Electroacoustic Evaluation For Hear	N/A
92595	Electroacoustic Evaluation For Hear	N/A
92596	Ear Protector Attenuation Measureme	N/A
92597	Evaluation For Use And/Or Fitting Of Voice Prosthesis	N/A
92601	Diagnostic Analysis Of Cochlear Imp	N/A
92602	Diagnostic Analysis Of Cochlear Imp	N/A
92603	Diagnostic Analysis Of Cochlear Imp	N/A
92604	Diagnostic Analysis Of Cochlear Imp	N/A
92620	Auditory Function, 60 Min	N/A
92621	Auditory Function, + 15 Min	N/A
92625	Tinnitus Assessment	N/A
92626	Eval Aud Rehab Status	N/A
92627	Eval Aud Status Rehab Add-On	N/A
92630	Aud Rehab Pre-Ling Hear Loss	N/A
92633	Aud Rehab Postling Hear Loss	N/A
92700	Unlisted Otorhinolaryngological Ser	N/A

EPSDT Hearing Aid Codes Authorized by the Service Authorization Contractor/KePRO

- Other professional/evaluation services are reimbursed using CPT codes 92551-92700
- Hearing Aid-Related services such as fitting, dispensation, supplies and ear molds do not require authorization

PA Service type (used to request service type)	Procedure Codes	Procedure Code Definition
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0092 EPSDT Specialized Services - Hearing Aids and Related Devices	V5014	Repair/Modification Of Hearing Aid
	V5030	Hearing Aid, Monaural, Body Worn, Air Conduction
	V5040	Hearing Aid, Monaural, Body Worn, Bone Conduction
	V5050	Hearing Aid, Monaural, In The Ear (Ite)
	V5060	Hearing Aid, Monaural, Behind The Ear (Bte)
	V5070	Glasses, Air Conduction
	V5080	Glasses, Bone Conduction
	V5095	Semi-Implantable Middle Ear Hearing
	V5100	Hearing Aid, Bilateral, Body Worn
	V5120	Binaural, Body
	V5130	Hearing Aid, Binaural, Ite
	V5140	Hearing Aid, Binaural, Bte
	V5150	Binaural, Glasses
	V5170	Hearing Aid, Cros, In The Ear
	V5180	Hearing Aid, Cros, Behind The Ear
	V5210	Hearing Aid, Bicros, In The Ear
	V5220	Hearing Aid, Bicros, Behind The Ear
	V5242	Hearing Aid, Analog, Monaural, Cic (Completely In The Ear Canal)
	V5243	Hearing Aid, Analog, Monaural, Itc (In The Canal)
	V5244	Hearing Aid / Digitally Programmable Analog / Monaural / CIC
	V5245	Hearing Aid / Digitally Programmable Analog / Monaural / ITC (Canal)
	V5246	Hearing Aid / Digitally Programmable Analog / Monaural / ITE (In-the-Ear)
	V5247	Hearing Aid / Digitally Programmable Analog / Monaural / BTE (Behind-the-Ear)
	V5248	Hearing Aid, Analog, Binaural, Cic
	V5249	Hearing Aid, Analog, Binaural, Itc
	V5250	Hearing Aid / Digitally Programmable / Analog /Binaural /CIC (Completely in Canal)
	V5251	Hearing Aid / Digitally Programmable / Analog /Binaural /ITC (Canal)

PA Service type (used to request service type) cont.	Procedure Codes	Procedure Code Definition
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0092 EPSDT Specialized Services - Hearing Aids and Related Devices	V5252	Hearing Aid / Digitally Programmable / Analog /Binaural /ITE (In-the-Ear)
	V5253	Hearing Aid / Digitally Programmable / Analog /Binaural /BTE(Behind-the Ear)
	V5254	Hearing Aid, Digital, Monaural, Cic
	V5255	Hearing Aid, Digital, Monaural, Itc
	V5256	Hearing Aid, Digital, Monaural, Ite
	V5257	Hearing Aid, Digital Monaural Bte
	V5258	Hearing Aid, Digital, Binaural, Cic
	V5259	Hearing Aid, Digital, Binaural, Itc
	V5260	Hearing Aid, Digital, Binaural, Ite
	V5261	Hearing Aid, Digital, Binaural, Bte
	V5264	Ear Mold/ Insert, Not Disposable, Any Type
	V5266	Battery For Use In Hearing Device
	V5267	Hearing Aid Supplies
	V5273	Assistive Listening Device Cochlear Implant Type
	V5274	Assistive Listening Device (Not Otherwise Classified)
	V5281	Assistive Listening Device, FM system, Monaural
	V5282	Assistive Listening Device, FM system, Binaural
	V5283	Assistive Listening Device, FM /DM Neck, loop induction receiver
	V5284	Assistive Listening Device, FM /DM, ear level receiver
	V5285	Assistive Listening Device, FM /DM, direct audio input
	V5286	Assistive Listening Device, personal FM /DM blue tooth receiver
	V5287	Assistive Listening Device, personal FM /DM receiver, not otherwise classified
	V5288	Assistive Listening Device, personal FM /DM transmitter, assistive listening device
	V5289	Assistive Listening Device, Personal FM/DM Adapter/Boot coupling Device for receiver, any type
	V5290	Assistive Listening Device, Transmitter or Microphone, any type
	V5298	Hearing Aid, Not Otherwise Classifi
	V5299	Hearing Service, Miscellaneous